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	345289	A. BUILDING _____ B. WING _____	C 11/28/2018

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F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to accurately code the Minimum Data Set Assessment for 4 of 19 residents whose MDS was reviewed (Resident #17, #2, #9 and #7). The findings included: 1. Resident #17 was admitted to the facility on 11/13/14 and had a diagnosis of hereditary spastic paraplegia (impairment in motor and sensory function of the lower extremities). The Annual Minimum Data Set (MDS) Assessment dated 10/8/18 revealed the resident had moderate cognitive impairment, required extensive assistance for bed mobility and was non-ambulatory. The MDS noted under Section P that bed rails were used daily and were coded as a restraint for the resident. On 11/28/18 at 8:47 AM an interview was conducted with the MDS nurse. The Nurse stated the RAI (Resident Assessment Instrument) Manual now gave instructions to code all side rails as a restraint and had been coding all resident ' s side rails as a restraint. Review of the section of the RAI Manual referred to by the MDS Nurse was reviewed with the nurse and the manual stated to code side rails as a restraint if the device met the definition of a restraint. The MDS Nurse stated the side rails were not a	F 641	Preparation and or execution of this Plan of Correction does not constitute admission by the Provider of the truth of the Facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely because it is required by law. This Plan of Correction is Submitted as our Allegation of Compliance. 1) Resident #17, #2, #9 and #7 have had a modified assessment to correct the coding error of which was transmitted and accepted by the state on 12/3/2018. 2) All residents with use of side rails for the purpose of an assistive device had the potential for the coding error. All resident's with side rail use have been audited to ensure correct coding under Section P of the MDS. Audit was completed on 12/13/2018 for accurate coding. 3) Licensed Administrator to educate MDS Coordinator and Nurse Administration on the RAI Interpretation of the Federal Regulations of side rail use on 12/20/2018. MDS Coordinator to complete weekly audits of all new admits X seven weeks to determine if side rails	12/26/18

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

Electronically Signed | 12/14/2018

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F 641	Continued From page 1 restraint for this resident but thought she was coding them as instructed by the RAI Manual. The MDS Nurse stated she had been incorrect in her interpretation of the RAI Manual. On 11/28/18 at 11:04 AM the Director of Nursing stated in an interview she expected the MDS to be coded accurately. 2. Resident #2 was admitted to the facility on 3/28/14 and had a diagnosis of chronic obstructive pulmonary disease (COPD), dysphagia (difficulty swallowing) and pulmonary embolism (blood clot in the lung). The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 8/31/18 revealed the resident was cognitively intact and required limited assistance with bed mobility and transfers. Under Section P of the MDS it was noted that bed rails were used daily and were coded as a restraint for the resident. On 11/26/18 at 2:03 PM during a resident interview the resident's bed was noted to have 2 one quarter side rails in the up position on the bed. The Resident stated he used the controls on the side rails to elevate the head of his bed and used the bed rails to assist with turning when in bed. The Resident stated the bed rails did not restrict his movement or prevent him from getting out of bed. On 11/28/18 at 8:47 AM an interview was conducted with the MDS nurse. The Nurse stated the RAI (Resident Assessment Instrument) Manual now gave instructions to code all side rails as a restraint and had been coding all resident's side rails as a restraint. Review of the	F 641	for assistive devices have been coded accurately on the MDS. Any discrepancies will be modified in accordance to RAI guidelines at time of identification. 4) Administrator to audit side rail coding Monthly x times three months. Any trending or inaccuracies identified will be reported through the Quality Assurance and Process Improvement Committee for review and recommendations for continued compliance.	

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F 641	Continued From page 2 section of the RAI Manual referred to by the MDS Nurse was reviewed with the nurse and the manual stated to code side rails as a restraint if the device met the definition of a restraint. The MDS Nurse stated the side rails were not a restraint for this resident but thought she was coding them as instructed by the RAI Manual. The MDS Nurse stated she had been incorrect in her interpretation of the RAI Manual. On 11/28/18 at 11:04 AM the Director of Nursing stated in an interview she expected the MDS to be coded accurately. 3. Resident #9 was admitted to the facility on 1/19/2015 with diagnoses to include atrial fibrillation, and edema. Review of the quarterly Minimum Data Set (MDS) assessment dated 9/7/2018 revealed her cognition to be intact and side rails were coded as a restraint. On 11/28/18 at 8:47 AM an interview was conducted with the MDS nurse. The Nurse stated the RAI (Resident Assessment Instrument) Manual now gave instructions to code all side rails as a restraint and had been coding all resident's side rails as a restraint. Review of the section of the RAI Manual referred to by the MDS Nurse was reviewed with the nurse and the manual stated to code side rails as a restraint if the device met the definition of a restraint. The MDS Nurse stated the side rails were not a restraint for this resident but thought she was coding them as instructed by the RAI Manual.	F 641		

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F 641	Continued From page 3	F 641		

The MDS Nurse stated she had been incorrect in her interpretation of the RAI Manual.

On 11/28/2018 at 4:31 PM, an interview was conducted with the Director of Nursing (DON), who stated she expected the MDS to be coded accurately so that the care plan and interventions would be accurate.

4. Resident #7 was originally admitted to the facility on 12/15/16 with diagnoses including Muscle Weakness (generalized), Cerebral Infarction, Type 2 Diabetes Mellitus and Unspecified Symptoms & Signs Involving Cognitive Functions and Awareness. According to the most recent Quarterly Minimum Data Set (MDS) dated 9/24/18, Resident #7's cognition was intact. In the area of activities of daily living, Resident #7 was independent in bed mobility and transfers. She was independent with supervision in most areas of activities of daily living. Review of Section P Restraints and Alarms on the MDS revealed bed rails was coded as a restraint.

Review of Resident #7's Care Plan dated 9/24/18, revealed Resident #7 was care planned for bed rails which was noted to enhance the resident's quality of life due to overall weakness on the resident's left side. Interventions included Resident #7's ability to turn and reposition herself in bed and assess resident's need for mobility and ability to use quarter side rails for bed mobility every quarter and as needed.

On 11/28/18 at 8:47 AM an interview was conducted with the MDS nurse. The Nurse stated the RAI (Resident Assessment Instrument) Manual now gave instructions to code all side rails as a restraint and had been coding all

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F 641	Continued From page 4 resident's side rails as a restraint. Review of the section of the RAI Manual referred to by the MDS Nurse was reviewed with the nurse and the manual stated to code side rails as a restraint if the device met the definition of a restraint. The MDS Nurse stated the side rails were not a restraint for this resident but thought she was coding them as instructed by the RAI Manual. The MDS Nurse stated she had been incorrect in her interpretation of the RAI Manual. On 11/28/2018 at 4:31 PM, an interview was conducted with the Director of Nursing (DON), who stated she expected the MDS to be coded accurately so that the care plan and interventions would be accurate.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		12/26/18

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F 656	Continued From page 5 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a Comprehensive Care Plan for 1 of 19 residents reviewed. The Care Plan failed to include the resident was to be transferred with a mechanical lift. (Resident #17). The findings included: Resident #17 was admitted to the facility on 11/13/14 and had a diagnosis of hereditary spastic paraplegia (impairment in motor and sensory function of the lower extremities). The Annual Minimum Data Set (MDS) Assessment dated 10/8/18 noted the resident had moderate cognitive impairment, required	F 656	1) Resident #17 Care Plan has been updated to reflect accurate assessment for transfer abilities. 2) All residents requiring mechanical lift transfers had risk for inaccurate care plan. On 12/10/2018 Director of Nurses and or designee interviewed staff, audited CNA summaries and Care Plans to ensure accuracy for 100% of current residents. 3) All Licensed Nurses were educated on editing and updating Care Plans per changes that occur regarding residents condition from 12/11-12/17/2018. MDS Coordinator & or Designee completed an	

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F 656	Continued From page 6 extensive assistance with bed mobility, was not ambulatory, transfers had occurred only once or twice during the assessment period and the resident used a wheelchair for mobility. The resident's Care Plan last reviewed by the facility on 10/12/18 noted the resident required extensive assistance related to the inability to move the lower extremities and overall weakness. The Care Plan noted with the use of the bed rail, the resident would have an enhanced quality of life as evidenced by the ability to transfer from the bed to a wheelchair with one person assist. Review of the nursing assistant's care guide for Resident #17 revealed the resident was to be transferred with a total mechanical lift with the assistance of 2 persons. On 11/28/18 at 11:11 AM an interview was conducted with NA (nursing assistant) #1 who was assigned to Resident #17. The NA stated the resident could not move his legs and had foot drop and was a total transfer with a mechanical lift with 2 person assist. On 11/28/18 at 1:20 PM Clinical Manager #1 stated in an interview that Resident #17 had been transferred with a total mechanical lift since admission to the facility. On 11/28/18 at 1:42 PM the MDS Nurse was not available for an interview during the rest of the survey. On 11/28/18 at 4:30 PM the Director of Nursing (DON) stated in an interview she did not understand why the MDS nurse wrote the care plan the way she did and it was her expectation	F 656	audit on all residents to validate accuracy of Care Plans transfer abilities based off observation, record review & interview. Weekly audits of new admissions will be completed by MDS Coordinator/Designee x seven weeks. 4) Director of Nurses and or Designee will review monthly x three months for sustained compliance. Results to be reported to the Quality Assurance & Process Improvement Committee for review and recommendations for further needs.	

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F 656	Continued From page 7 the care plan be accurate and complete.	F 656		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 690		12/26/18

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F 690	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to clean a urinary catheter port before flushing with normal saline for 1 of 2 residents (Resident #16) reviewed for urinary catheters. The findings included: Resident #16 was admitted to the facility on 3/18/2015 with diagnoses to include dementia, and neuromuscular dysfunction of the bladder. A review of the quarterly Minimum Data Set (MDS) assessment dated 9/27/2018 revealed his cognition was severely impaired, and he had an indwelling urinary catheter. A Physician order dated 6/30/2015 read: Irrigate bladder with 120 milliliters (ML) of Normal Saline (NS) daily. On 11/28/2018 at 8:24 AM, an observation was conducted of a urinary catheter flush with Nurse #4. The Nurse entered the room of Resident #16. The catheter bag was enclosed in a privacy bag and the urine in the bag was clear yellow. The nurse used a 30 ML syringe, filled it with sterile NS and inserted the syringe into a port on the urinary catheter tubing and flushed the catheter, repeating 3 additional times for a total of 120 ML. During an interview immediately following the flush, the nurse was asked if she ever thought to clean the port before flushing the urinary system. Nurse #4 held up an alcohol pad and stated they always wiped the port with the alcohol wipe before the flush, but she had forgotten to take a wipe in the room with her.	F 690	1) Resident #16 has subsequently received appropriate Standards of Care Practice regarding catheter flushes utilizing aseptic technique. 2) Any Resident that requires catheter care flushes had potential for risk. From 12/9-12/15/2018 audit completed on all residents with current flush orders to ensure competency of nurses while performing task. 3) All Nursing Staff to be educated on aseptic technique for accessing irrigation port by RN Staff Development Coordinator/and or designee from 12/12 to 12/21/2018. RN Clinical Managers to complete observation of two catheter port accesses ensuring proper techniques each week x 7 weeks. 4) Clinical Managers will report results of said audits to Quality Assurance & Process Improvement Committee each month x 3 months for review and recommendation of further interventions.	

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F 690	Continued From page 9 On 11/28/2018 at 11:39 AM, an interview was conducted with the Director of Nursing (DON), who stated she expected the nurses to absolutely clean the urinary port before conducting a flush.	F 690		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		12/26/18

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F 756	Continued From page 10 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, pharmacist and staff interviews the pharmacist failed to recommend an AIMS (Abnormal Involuntary Movements) test for 1 of 2 residents reviewed for antipsychotic medications (Resident #8) and failed to recommend a gradual dose reduction for 1 of 6 residents reviewed who received psychoactive medications (Resident #46). The findings included: 1. Resident #8 was admitted to the facility on 1/18/17 and had a diagnosis of Alzheimer's disease and dementia with behaviors. Review of the clinical record revealed Resident #8 had received Risperdal (antipsychotic medication) continuously since August 2, 2017. Review of the clinical record revealed the last AIMS (Abnormal Involuntary Movements) test on the clinical record was dated 12/26/17. Tardive Dyskinesia is a chronic and potentially irreversible drug induced movement disorder and one of the possible side effects of antipsychotic medications. An AIMS test is done to detect and tract involuntary movements in persons taking antipsychotic medications.	F 756	1) Resident #8 AIMS was completed on 11/28/2018. Resident #46's Primary Care Physician on 12/3/2018 reviewed for Risk vs Benefits and made no recommendation for changes at this time. 2) Any resident with current orders of antipsychotic medications would have been at risk for untimely completion of AIMS. Pharmacist/RN Clinical Managers completed 100% audit of all residents receiving antipsychotic medications to ensure AIMS were completed on 12/14/2018. Any resident on a psychotropic medication would have been at risk for untimely completion of a GDRs. All residents on a psychotropic medication were reviewed by Pharmacist and RN Clinical Managers on 12/14/2018 for timely GDRs. 3) Pharmacist to provide education on Federal regulation of AIMS & GDRs to Nursing Administration on 12/20/2018. Pharmacist to audit for compliance monthly regarding psychotropic drugs and need for GDR. RN Clinical Managers to audit for AIMS on new Admissions, any warranted resident condition changes and routine Q six months.	

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F 756	Continued From page 11 On 11/28/18 at 12:00 PM an interview was conducted with Clinical Manager #2. The Clinical Manager was observed to review the clinical record for Resident #8 and stated she did not see an AIMS since 12/26/17. The Clinical Manager further stated they do AIMS test every 6 months on residents on antipsychotic medications and they were usually done in January and June. The Clinical Manager was unable to explain why an AIMS test was not conducted for the resident. On 11/28/18 at 4:35 PM an interview was conducted with the Interim Director of Nursing (DON). The DON stated she expected the AIMS test to be done per protocol. 2. Resident #46 was admitted to the facility on 2/26/2016 with diagnoses to included major depressive disorder and congestive heart failure. A review of the quarterly Minimum Data Set (MDS) assessment dated 11/21/2018 revealed her cognition was intact and she had received antidepressant medication for 7 out of 7 days of the look back period. A review of the monthly Pharmacy notes from 1/25/2018 through 10/25/2018 all documented "no recommendations". On 11/28/2018 at 11:23 AM, an interview was conducted with the Pharmacist who stated she had looked at antidepressant medications for residents twice this past year. The Pharmacist stated she would talk to the previous Director of Nursing (DON) and the DON would write down information and implement it. The Pharmacist stated she did make recommendations for gradual dose reductions (GDR), but always documented "no recommendations" since she thought the DON would document them. The	F 756	4) Results of audits to be reported by Pharmacist and RN Clinical Managers for review & recommendations for further needs by the Quality Assurance & Process Improvement Committee monthly x 3.	

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SENTARA NURSING CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

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F 756	Continued From page 12 Pharmacist further stated she told the DON to scan the documents into the medical record, and since there were no records found, she shouldn't have left the documentation up to someone else, as the "no recommendations" note in the record was not accurate. The Pharmacist stated she had no records to provide that any GDR's had been recommended for Resident #46. On 11/28/2018 at 4:30 PM, an interview was conducted with the DON who stated she expected the Pharmacist to document in the medical record per the guidelines and expected dose reductions recommendations to be conducted per the guidelines.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		12/26/18

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F 758	Continued From page 13 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff and pharmacist interviews the pharmacist failed to address a gradual dose reduction for antidepressant medications for 1 of 6 residents (Resident #46) who had their medications reviewed, and the facility failed to complete an Abnormal Involuntary Movement (AIMS) test for 1 of 2 residents (Resident #8) on antipsychotic medications. The findings included:	F 758	1) Resident #46's PRN Antianxiety Medication has since been discontinued by Primary Care Physician. Resident #8 has subsequently received an AIMS test. 2) Any resident with orders for a PRN Psychotropic medication were at risk. On 12/14/2018 Pharmacist and RN Clinical Managers audited 100% of current residents for PRN Psychotropic Medications orders. MD consulted and	

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F 758	Continued From page 14 1. Resident #46 was admitted to the facility on 2/26/2016 with diagnoses to included major depressive disorder and congestive heart failure. A review of the quarterly Minimum Data Set (MDS) assessment dated 11/21/2018 revealed her cognition was intact and she had received antidepressant medication for 7 out of 7 days of the look back period. A review of the monthly Pharmacy notes from 1/25/2018 through 10/25/2018 all documented "no recommendations". On 11/28/2018 at 11:23 AM, an interview was conducted with the Pharmacist who stated she had looked at antidepressant medications for residents twice this past year. The Pharmacist stated she would talk to the previous Director of Nursing (DON) and the DON would write down information and implement it. The Pharmacist stated she did make recommendations for gradual dose reductions (GDR), but always documented "no recommendations" since she thought the DON would document them. The Pharmacist further stated she told the DON to scan the documents into the medical record, and since there were no records found, she shouldn't have left the documentation up to someone else. The Pharmacist stated she had no records to provide that any GDR's had been recommended for Resident #46. On 11/28/2018 at 2:54 PM, an interview was conducted with the Physician. The Physician stated the pharmacist used to recommend dose reductions and he would make a judgement on those requests monthly, but that practice had stopped quite a few months ago. The Physician	F 758	determined continual appropriate use or discontinuation. 3) Administrator to educate Nursing Administration to the requirements of the Federal Tag 758 on 12/20/2018. RN Clinical Managers to complete audit of all residents on PRN Psychotropic Medications weekly x seven weeks. 4) Pharmacist monthly review to include PRN Psychotropic recommendations and to report results to the Quality Assurance and Process Improvement Committee for review and recommendation for further needs.	

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F 758	Continued From page 15	F 758		

stated if a dose reduction was brought to his attention he would address it.

On 11/28/2018 at 4:30 PM, an interview was conducted with the DON who stated she expected the Pharmacist to document in the medical record per the guidelines and expected dose reductions to be conducted per the guidelines.

2. Resident #8 was admitted to the facility on 1/18/17 and had a diagnosis of Alzheimer's disease and dementia with behaviors.

Review of the clinical record revealed Resident #8 had received Risperdal (antipsychotic medication) continuously since August 2, 2017.

Review of the clinical record revealed the last AIMS (Abnormal Involuntary Movements) test on the record was dated 12/26/17.

Tardive Dyskinesia is a chronic and potentially irreversible drug induced movement disorder and one of the possible side effects of antipsychotic medications. An AIMS test is done to detect and tract involuntary movements in persons taking antipsychotic medications.

On 11/28/18 at 12:00 PM an interview was conducted with Clinical Manager #2. The Clinical Manager was observed to review the clinical record for Resident #8 and stated she did not see an AIMS since 12/26/17. The Clinical Manager further stated they do AIMS test every 6 months on residents on antipsychotic medications and they were usually done in January and June. The Clinical Manager was unable to explain why an AIMS test was not conducted for the resident.

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F 758	Continued From page 16 On 11/28/18 at 4:35 PM an interview was conducted with the Interim Director of Nursing (DON). The DON stated she expected the AIMS test to be done per protocol.	F 758		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(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: §483.80(a)(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; §483.80(a)(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	F 880		12/26/18

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F 880	Continued From page 17 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 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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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, record review, and staff interviews, the facility failed to disinfect glucometers per the manufacturer's recommendations after use to check blood sugars for 3 of 3 residents (Resident #24, #29,	F 880	1) Resident #24, #29 and #9 have subsequently utilized glucometers cleaned to the manufacturers specifications. 2) Any residents whose condition	

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F 880	Continued From page 18 and #7) observed for blood sugar checks. The findings included: The facility's policy titled Whole Blood Glucose Testing by Roche "Accu-chek Inform II" revised on 7/2015, and subtitled Maintenance- Cleaning the Outside of the Meter: Clean the outside of meter after each patient use read: 1. Place meter on level surface prior to cleaning and disinfecting. Use Super Sani-Cloth or Clorox Germicidal Wipes. Wait the recommended contact time according to label on disinfectant wipe and hospital policy. The facility's germicidal disposable wipe included on the label Super Sani cloth disinfects in 2 minutes bactericidal, tuberculocidal, and viricidal. Directions on the back of the container read: Allow treated surface to remain wet for a full 2 minutes. Let air dry. An observation of a blood sugar check was conducted on 11/26/2018 at 12:31 PM with Nurse #1. Nurse #1 conducted a blood sugar check on Resident #24. At 12:33 PM on 11/26/2018 the Nurse wiped the glucometer with a disinfectant wipe for approximately 10 seconds and threw the wipe away and laid the glucometer on the cart. The Nurse stated she was in-serviced on cleaning the glucometer every year and they were to wipe the glucometer and then let it air dry for 3 minutes before using it again. The nurse stated the wipe container said to wait for 2 minutes, but she liked to let the glucometer dry for 3 minutes. An observation of a blood sugar check was conducted on 11/27/2018 at 11:14 AM with Nurse #2. The Nurse readied the glucometer, gathered	F 880	required use of glucometers were at risk for deviated practice. Facility utilized methods of Hand Outs, demonstration and verbal instruction to convey proper technique has been completed on glucometer cleaning by the RN Clinical Managers. 3) RN Staff Development Coordinator/Designee to educate all staff on the manufacturers recommended guidelines of the Sani wipes from 11/27-12/25/2018. Glucometer cleaning audits to be conducted by Nursing Administration five times each week x seven weeks for continued compliance. 4) RN SDC & RN Clinical Managers to report results of audits monthly x 2 to the Quality Assurance & Process Improvement Committee for review and recommendations for further needs.	

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F 880	Continued From page 19	F 880		

her supplies and conducted the blood sugar check on Resident #29. At 11:17 AM 11/27/2018 the nurse wiped the glucometer with a disinfectant wipe for approximately 10 seconds, threw the wipe away and set the glucometer on the medication cart. Nurse #2 stated the glucometer was dry at 11:18 AM, but she would still have to wait for 2 minutes before she could use the glucometer again, as that is what she had been taught, and that was how she cleaned it.

An observation of a blood sugar check was conducted on 11/27/2018 at 11:40 AM with Nurse #3 with Resident #7. Nurse #3 gathered her supplies and conducted the blood sugar check. On 11/27/2018 at 11:46 AM, the nurse wiped the glucometer with a disinfectant wipe for approximately 10 seconds, threw the wipe away and set the glucometer on the medication cart. The Nurse stated she would let the glucometer dry for 2 minutes like the wipe container said, but she usually waited 2 to 3 minutes. At 11:47 AM, the nurse stated the glucometer looked dry, but she would still give it 3 minutes before use.

On 11/27/2018 at 2:31 PM, an interview was conducted with the Staff Development Coordinator (SDC). The SDC stated she had instructed staff to thoroughly clean the glucometer with a wipe and then let it dry for 2 minutes. The SDC retrieved a container of wipes and stated the label stated to allow treated surfaces to remain wet for a full 2 minutes, then let air dry, and she interpreted that to mean the glucometer did not have to be wiped for 2 minutes, but to wet the surface and let it air dry on its own. The SDC called the manufacturer of the wipes on the phone and the manufacturer representative stated the item being cleaned had

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F 880	Continued From page 20 to stay wet for the full 2 minutes in order to be disinfected. On 11/27/2018 at 2:50 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she expected the glucometer to be cleaned after every use with the disinfectant wipe per the manufacturer instructions, which meant the glucometer had to remain wet for 2 minutes before air drying.	F 880		