STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345106	A. BUILDING _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY RIDGE	2140 MEDICAL PARK DRIVE HICKORY, NC 28602

(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
E 000	Initial Comments An unannounced Recertification survey was conducted 9-16-19 through 9-19-19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID CWR811.	E 000		
F 656 SS=F	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 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	F 656		10/13/19

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

Electronically Signed | 10/13/2019

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F 656	Continued From page 1 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 develop and implement care plan interventions for 5 of 5 insulin dependent residents (Resident #38, Resident #21, Resident #97, Resident #90 and Resident #15) reviewed for unnecessary medication review. The findings included: 1.a. Resident #38 was admitted to the facility on 5/14/19 with a diagnosis that included Diabetes and cognitive communication deficit. The quarterly Minimum Data Set (MDS) assessment dated 7/17/19 revealed Resident #38 was severely cognitively impaired. The MDS further revealed the resident was diabetic and received injections. Review of Resident #38 physician order dated 5/14/19 stated Humalog 10 units three times a day. Review of Resident # 38 physician order dated 8/9/19 stated Lantus 21 units once daily.	F 656	1. Those residents, #38,#21,#97,#90,and #15 were care planned for Diabetes to monitor for signs of hyper/hypoglycemia and interventions by Registered Nurse Case Manager on 9/20/19. 2. The Registered Nurse Case Managers were in serviced by Administrator on 10/7/19. The Registered Nurse Case Manager reviewed and added care plans for 29 residents with a diagnosis of diabetes and was completed on 10/8/19. 3. The Registered Nurse Case Manager will review new admissions to ensure diabetes is included on the initial care plan. Also, Diabetic care plans were added to the admission check off list. Nurses were in serviced on Diabetic care plans by 10/13/19. 4. The Quality Assurance Registered Nurse will review the weekly care plan list and will review care plans of those residents that have a diagnosis of diabetes to ensure care plans are in place weekly and report to the Quality Assurance Committee times three (3) and	

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F 656	Continued From page 2 Review of Resident #38 medical record revealed no care plan or interventions for the use of insulin for the diagnosis of Diabetes. b. Resident # 21 was admitted to the facility on 2/3/15 with a diagnosis that included Diabetes Type 2, and Dementia. The most recent MDS assessment dated 6/26/19 revealed Resident #21 was moderately cognitively impaired, had a diagnosis of Diabetes and received insulin injections. Review of Resident #21 physician order dated 5/18/19 stated Novolin 10 units daily at bedtime. Review of Resident #21 physician order dated 6/25/19 stated Novolin 5 units daily at 7:30AM. Review of Resident #21 physician order dated 9/3/19 stated Levemir 33 units daily at 7:30AM. Review of Resident #21 medical record revealed no care plan or interventions for the use of insulin for the diagnosis of diabetes. c. Resident #97 was admitted to the facility on 8/6/19 with a diagnosis that included Diabetes Mellitus, Alzheimer's Disease, localized edema and pulmonary hypertension. The most recent MDS assessment dated 8/27/19 revealed Resident #97 was cognitively impaired, had a diagnosis of diabetes and received insulin injections. Review of Resident #97 physician order dated 8/30/19 stated Levemir 21 units daily at 7:30AM with administration instructions that included hold	F 656	then quarterly times three (3). The interdisciplinary care plan team will continue to do walking rounds as they review each care plan. 5. Dates of Corrective action is 10/13/19	

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F 656	Continued From page 3	F 656		

insulin if blood sugar was below 100.

Review of Resident #97 medical record revealed no care plan or interventions for the use of insulin for the diagnosis of diabetes.

d. Resident #90 was admitted to the facility on 12/15/16 with a diagnosis that include Diabetes Type 2, Long term use of insulin, chronic kidney disease and Alzheimer's.

The most recent MDS assessment dated 8/21/19 revealed Resident #90 was cognitively impaired, had a diagnosis of Diabetes and received insulin injections.

Review of Resident #90 physician order dated 5/2/18 stated Lantus decrease to 10 units daily at 8:00AM.

Review of Resident #90 medical record revealed no care plan or interventions for the use of insulin for the diagnosis of Diabetes.

e. Resident # 15 was admitted to the facility on 7/19/16 with a diagnosis that included Diabetes Type 2, Alzheimer's disease, peripheral vascular disease and long-term use of oral hypoglycemic drugs.

The most recent MDS assessment dated 8/4/19 revealed Resident #15 was cognitively impaired, had a diagnosis of Diabetes and received insulin injections.

Review of Resident #15 physician order dated 4/15/19 stated Levemir dose decreased to 18 units daily at 8:00am.

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F 656	Continued From page 4 Review of Resident #15 medical record revealed no care plan or interventions for the use of insulin for the diagnosis of diabetes. In an interview with MDS Coordinator #1 on 9/19/19 at 1:28 PM reveled she had not care planned the use of insulin due to the resident having a diagnosis of diabetes. She further revealed residents that had a diagnosis of diabetes was not care planned because it was a nursing standard of practice that did not require care planning. An interview with the Director of Nursing (DON) on 9/19/19 at 4:00 PM revealed insulin did required monitoring and was a nursing standard of practice. Due to insulin requiring monitoring it should have been care planned to include interventions. An interview with the Administrator on 09/19/19 at 4:00 PM revealed that there should have been a care plan in place for a resident that is diabetic and requires insulin.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to assess 1 of 3 sampled residents positioning device (Resident #62).	F 658	1. Resident #62, was assessed and the hemi tray was not needed so it was removed by The Quality Assurance Registered Nurse. The nursing	10/13/19

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F 658	Continued From page 5 Findings included: Resident #62 was admitted to facility 10/05/18 with the diagnoses that included quadriplegia C1-C4 complete with fusion, Dementia, Parkinson's Disease, dysphagia and depression. Review of the Minimum Data Set Assessment (MDS) dated 7/17/19 revealed Resident #62 was cognitively intact. The MDS further revealed Resident #62 required extensive assistance for mobility which included sit to stand and movement about the facility. A review of Resident #62's incident report dated 7/26/19 revealed she had a fall from her wheelchair while in the TV room. The note further revealed she had a lap tray attached to her wheelchair at the time of her fall. The review of resident #62 care plan 7/30/19 revealed Resident #62 had the potential to fall, get hurt and had impaired physical mobility. The goal stated Resident #62 would avoid major injury from a fall. The care plan further indicated Resident #62 had a hard time moving, frequently fell, got tired quickly and would lose her balance. Review of Resident #62 medical record revealed no physician order for the use of a lap tray. Review of Resident #62 occupational therapy assessments revealed no indication of use of a lap tray. An observation of Resident #62 on 9/16/19 at 11:54 am revealed her to be in the common area seated in her wheelchair. Resident #62's left arm	F 658	assessment for trialing an assistive device (hemi tray)was initiated as an intervention but the hemi tray was not removed after the two (2) week trial period. Hemi Tray was removed on 9/16/19 by the Quality Assurance Registered Nurse. 2. All residents were assessed for positioning devices, Forty-eight (48) were found to have positioning devices and were assessed appropriately by the Director of Nursing, Assistant Director of Nursing/Staff Development and Quality Assurance Registered Nurse on 10/10/19. 3. Any positioning assistive device that is initiated by nursing for a two (2) week trial period will be documented in the residents medication record with the begin date and the end date. The nurse assigned will document progress. The Quality Assurance Nurse will evaluate and document the effectiveness of the assistive device after the two week trial period. Registered Nurses and Licensed Practical Nurses were educated on by 10/13/19. 4. Quality Assurance Nurse will report weekly any resident that are undergoing a nursing trial of positioning equipment times four (4) weeks and then quarterly times three (3) to ensure assessment has been completed and positioning device is appropriate. The interdisciplinary care plan team will continue to do walking rounds as they review each care plan. 5. Date of Corrective action is 10/13/19.	

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F 658	Continued From page 6	F 658		

was observed to be resting on a lap tray attached to her wheelchair.

An interview was attempted with Resident #62 on 9/18/19 at 1:19pm. Resident #62 was unable to answer questions as asked.

Nurse #6 was interviewed on 9/18/19 at 1:51 PM revealed that Resident #62 used the lap tray to keep resident upright in her wheelchair.

Interview with Occupational Therapy Assistant #1 on 9/18/19 at 2:53 PM revealed that Resident #62's lap tray had not been assessed by the therapy department.

Nurse #5 was interviewed on 9/18/19 at 2:54PM. During this interview, the Resident #62's incident report dated 7/26/19 was reviewed with Nurse #5. She indicated that she had provided Resident #62 with the lap tray as a nursing intervention due the resident leaning forward in her chair. Nurse #5 further stated she had intended to use the lap tray for a 2-week trial period and she had not documented the use of the lap tray and did not have documentation indicating the day the trial for the lap tray began. She further stated she the tray was removed on 9/16/19 because Resident #62 was unable to lift the tray independently. Nurse #5 also stated that a physician order and care plan should have been initiated in the instance the trial period extended beyond the 2 weeks.

An interview with Nurse #3 on 9/18/19 at 3:05 PM revealed the nursing assistant worksheet and electronic medical record showed no indications for use of the lap tray.

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F 658	Continued From page 7 Interview with Nursing Assistant (NA) #1 on 9/19/19 at 9:55 AM revealed Resident #62 had used a lap tray to prevent falls. NA #1 was unable to recall how long the lap tray was used but indicated it was used at times Resident #62 was up in her wheelchair. On 9/19/19 4:00 PM an interview with Director of Nursing (DON) revealed an assessment was not needed if the tray was to be used as a trial period. However, if the device was to be continued, it would need to be assessed. The DON stated the use of the lap tray should have been addressed in the staff meetings to determine its appropriateness and need for a formal assessment. An interview with the Administrator on 9/19/19 at 4:00 PM revealed that the use of the lap tray should have been assessed at the end of the 2-week trial period.	F 658		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		10/13/19

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F 761	Continued From page 8 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to maintain proper temperatures in 2 of 4 refrigerators reviewed for medication storage (One white refrigerator and one black refrigerator located in the medication storage room on 100/200 hall). The findings included: 09/19/19 09:58 AM Observation of refrigerator temperatures recorded on clipboard on top of each refrigerator. Instructions on bottom of refrigerator temperature log sheet recorded daily stated: "Temperatures are taken daily on third shift....Initial and record temp for each day. If temperature is not between 34-42 degrees, a work order should be filled out for maintenance to check." 1. The White medication storage refrigerator contained the following medications: a) Pneumovax 23 vaccine (container indicate storage temps should be between 36-46 degrees) b) Brovana 15 mcg (container indicate storage temps should be between 36-46 degrees) c) Energix-B Hepatitis B vaccine has red label on container that states "Do not freeze"	F 761	1. Medication refrigerator on the 100/200 neighborhood was not in range for storing medications according to the temperature log. Pharmacy was notified by the Director of Nursing on October 4, 2019 to ensure medications were safe to use. No medications were discarded. 2. All medication storage refrigerators were audited by Quality Assurance Registered Nurse to ensure appropriate temperatures were maintained. No other issues were identified. 3. Director of Nursing created a new temperature log to be placed with the appropriate temperature ranges. Temperature log is placed with each medication refrigerator. This has the correct temperature range according to policy; Director of nursing educated the nurses on the temperature logs and notifying when temperatures are out of range on 9/24/19 and 9/25/19. Registered Nurses and Licensed Practical Nurses were educated by 10/13/19. Director of Maintenance also replaced all of the thermometers that were in the medication	

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F 761	Continued From page 9 d) Promethazine HCl 25 mg (container indicate storage temps should be between 36-46 degrees) e) 12 Insulin Pens in bags f) Tubersol 5T (container indicate storage temps should be between 35-46 degrees) g) Prevnar 13 Pneumococcal vaccine (container indicate storage temp should be between 35-46 degrees) July 2019 temps for white refrigerator ranged between 30 and 38 degrees with temps out of range on the following dates: 7/2 - 32 degrees 7/3 - 32 degrees 7/5 - 32 degrees 7/6 - 31 degrees 7/7 - 32 degrees 7/8 - 31 degrees 7/9 - 32 degrees 7/10 - 32 degrees 7/13 - 30 degrees 7/16 - 32 degrees 7/17 - 30 degrees 7/18 - 32 degrees 7/19 - 30 degrees 7/24 - 32 degrees 7/11 and 7/12 Missing recorded temperatures 7/14 and 7/15 Missing recorded temperatures 7/20 and 7/21 Missing recorded temperatures 7/28 Missing recorded temperature August 2019 temps for white refrigerator ranged between 32 and 38 degrees with temps out of range on the following dates: 8/1 Missing recorded temperatures 8/8 - 32 degrees 8/4 Missing recorded temperatures 8/11 Missing recorded temperatures 8/17 Missing recorded temperatures	F 761	refrigerators on 10/10/19. 4. Quality Assurance Nurse will audit daily times two weeks, then weekly times three (3) then quarterly times three (3) to ensure temperatures are within range for medication refrigerators and will report findings to the Quality Assurance Committee. 5. Date of Corrective action is 10/13/19	

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F 761	Continued From page 10 8/18 Missing recorded temperatures 8/19 Missing recorded temperatures 8/22 Missing recorded temperatures 8/23 Missing recorded temperatures 8/30 Missing recorded temperatures 8/31 Missing recorded temperatures September 2019 temps for white refrigerator ranged between 31 and 40 degrees with missing and out of range recorded temps on: 9/7 Missing recorded temperatures 9/10 Missing recorded temperatures 9/11 32 degrees 9/12 Missing recorded temperatures 9/16 Missing recorded temperatures 2. The Black medication storage refrigerator contained the following medication: Intravenous Cefazolin labeled for resident #101 with freezing/below freezing temps recorded as follows: July 2019 Black refrigerator temps ranged between 30 and 36 degrees with missing recorded temps and temps out of range on: 7/5 - 32 degrees 7/6 - 32 degrees 7/7 - 30 degrees 7/8 - 31 degrees 7/9 - 30 degrees 7/10 - 32 degrees 7/11 and 7/12 Missing recorded temperatures 7/13 - 32 degrees 7/14 and 7/15 Missing recorded temperatures 7/19 - 32 degrees 7/20 and 7/21 Missing recorded temperatures 7/25- 32 degrees 7/26- 32 degrees 7/27- 32 degrees	F 761		

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F 761	Continued From page 11 7/28 and 7/29 Missing recorded temperatures 7/30 - 32 degrees August 2019 Black refrigerator temps ranged between 30 and 36 degrees with missing recorded temps on: 8/1 Missing recorded temperatures 8/3 and 8/4 Missing recorded temperatures 8/5 - 30 degrees 8/7- 32 degrees 8/8- 30 degrees 8/16 - 32 degrees 8/21 Missing recorded temperature 8/23 Missing recorded temperature 8/25- 32 degrees 8/30 - 32 degrees 8/31 Missing recorded temperature September 2019 Black refrigerator temps ranged between 30 and 40 degrees with missing recorded temps on: 9/2 - 30 degrees 9/3 - 32 degrees 9/5 - 32 degrees 9/7 Missing recorded temperature 9/10 Missing recorded temperature 9/12 and 9/13 Missing recorded temperature 9/16 Missing recorded temperature 09/19/19 09:58 AM Interview with nurse #2 stated that third shift nurses are responsible for recording temperature of refrigerator on temperature log. 09/19/19 01:28 PM Interview with maintenance manager: Asked him if he would expect a repair order if there was a problem with any of the medication refrigerators in the med rooms on each unit and he replied, "yes Ma'am". He also	F 761		

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F 761	Continued From page 12 stated that he has been doing maintenance at this facility for over 19 years. 09/19/19 03:47 PM Interviewed Nurse #1 in medication room on 100/200 wing. Asked if there were any reason medications would need to be moved from the refrigerators. She stated that would be reasonable in the event they needed to defrost the refrigerators. When asked if she had ever seen the medications moved for any reason, she stated she had not. She stated she has been employed at this facility since 2003. 09/19/19 03:35 PM Interview with DON regarding policy for medication storage in refrigerators in med rooms. DON stated night nurses check the refrigerators daily and documents temperatures on temperature logs. She stated when temps are out of range, medications are to be moved to another working refrigerator, and a repair order sent to maintenance to request repair.	F 761		
F 880 SS=D	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:	F 880		10/13/19

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	345106	A. BUILDING _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY RIDGE	2140 MEDICAL PARK DRIVE HICKORY, NC 28602

(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 880	Continued From page 13	F 880		

§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 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

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F 880	Continued From page 14 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 observations, interviews, and facility policy review, the facility 1) failed to adequately disinfect 1 of 1 glucometers according to disinfecting wipe manufacturer instructions, and 2) failed to separate clean and uncleaned glucometers in its medication storage cart for 3 of 3 reviewed during medication administration. Findings include: Review of the Facility Policy Titled BLOOD SAMPLING - CAPILLARY (FINGER STICKS), Manual: LSC Infection Control, Section: General Infection Control Practices, Date Approved: 2/22/10 Date Revised: 1/26/16 Approved by THG Paragraph 6, Section 2 read in part as follows: "If no visible organic material is present, disinfect the exterior surfaces after each use following the manufacturer's instructions using a cloth/wipe with either an EPA-registered detergent/germicide with a tuberculocidal or HBV/HIV label claim, or a dilute bleach solution of 1:10 (one-part bleach to 9 parts water) to 1:100 concentration. The disinfecting wipe instructions from the	F 880	1. Glucometer for resident #46 was disinfected and was put in a brand new plastic zip-lock bag that was closed on October 7, 2019. 2. The Director of Nursing reviewed residents that have blood glucose checks. There were 25 residents that have their own individual glucometer that received a brand new plastic zip-lock bag that was labeled, dated, and closed as of 10/8/2019. 3. The Assistant Director of Nursing/Staff Development Registered Nurse and Quality Assurance Registered Nurse educated staff on the appropriateness of disinfecting glucometer after each use and storing by 10/13/19. The new procedure for disinfecting and storing glucometers were added to the treatment medication record, 3rd shift nurse is to place glucometer in a new labeled, dated, and closed zip lock bag and signed off daily. 4. Quality Assurance Registered Nurse will observe weekly the disinfecting and storage of glucometers times three (3)	

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F 880	Continued From page 15 manufacturer read in part as follows: "Repeated use of the product may be required to ensure that the surface remains visibly wet for 2 minutes" Disinfecting wipes product claims it is effective against TB and MRSA after 3 minutes of use, and HIV-1, HBV, and HCV within 2 minutes of use. 1. On 09/19/19 at 08:26 AM Observed nurse #3 perform Blood Glucose Check (BGC) on resident #46. Upon completion of the BGC, the nurse placed the glucometer into its old, unzipped plastic bag and returned it to the drawer in the medication cart where several other glucometers are also stored in open/unzipped plastic bags. There were no disinfecting wipes used to clean resident #46 glucometer prior to placing it back into the original used bag. An interview with nurse #3 conducted on 09/18/19 4:55 pm. stated she cleans the glucometers once a day at the end of the day. The nurse demonstrated her disinfecting technique and was observed cleaning a glucometer with a disinfecting wipe. She donned gloves, placed glucometer on paper towel on countertop, wiped glucometer with disinfecting wipe and waited for it to dry. Dry time of wiped glucometer was 47.9 seconds from start of wipe. The nurse then placed the glucometer back into its original used bag. When asked if she ever placed glucometers into new zip close bag, the nurse said she does this after cleaning them at the end of the day. On 09/19/19 at 08:14 an interview with nurse #4 revealed that all blood sugars are completed around 6:30 a.m. and she uses a disinfecting wipe to clean glucometers. She said that she	F 880	and then quarterly times three (3)and will report to the Quality Assurance Committee. 5. Dates of corrective action is 10/13/19.	

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F 880	Continued From page 16	F 880		

cleans them between each use and that she wipes it for about 30 seconds, and then is done.

On 09/19/19 at 08:26 AM, following BGC on resident #46, observed nurse placing used glucometer into open used bag in drawer with 4 glucometers in the front of the drawer, and 6 more in the back of the same drawer. Glucometers were in individual zip bags for each resident, and all bags were unzipped and open to air. All bags appeared older and used more than one time. The open bags were stacked on top of each other with both clean and unclean glucometers in same drawer and touching one another.

On 09/19/19 at 08:32 AM Two other medication carts on 500/600 and 700/800 halls were observed to have open/unzipped glucometers in bags placed in the drawers in the same manner.

On 09/19/19 at 09:04 AM an interview was conducted with Director of Nursing (DON) regarding the infection control policy for glucometers. She stated that she knows the glucometers are kept in individual bags and are to be cleaned between every resident use. The DON said they are wiped with disinfecting wipes until they dry and placed back in the resident's bag. The glucometers are kept in the medication carts. Instructions on the canister for disinfecting wipes were shown to the DON where the need to remain wet with disinfecting solution for 2-minute duration is located. Upon reviewing the instructions, the DON stated she was not aware the glucometers needed to be wet for two minutes.