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	345039	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

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F 000	INITIAL COMMENTS The survey team entered the facility on 9/28/21 to conduct a complaint survey in conjunction with a revisit (Event ID #7QIJ12) and exited on 9/30/21. Additional information was obtained on 10/7/21 and 10/8/21. Therefore, the exit date was changed to 10/8/21. None (0) of the 5 complaint allegations were substantiated. However, Immediate Jeopardy was identified at: CFR 483.70 at tag F835 at a scope and severity (K) and CFR 483.80 at tag F880 at a scope and severity (K). The tags F835 and F880 did not constitute Substandard Quality of Care. Immediate Jeopardy began on 9/27/21 and was removed on 9/30/21.	F 000		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580		10/25/21

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

Electronically Signed | 10/22/2021

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F 580	Continued From page 1 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to notify the residents' Responsible Party (RP) after a shared glucose meter (glucometer) was used to complete blood glucose checks without being disinfected between multiple residents in accordance with the manufacturer's instructions. This occurred for 6 of 6 residents requiring blood glucose monitoring (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5 and Resident #6) and whose	F 580	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged	

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F 580	Continued From page 2 blood glucose levels were checked by an agency nurse (Nurse #1) assigned to care for them. The findings included: 1-a) Resident #1 was admitted to the facility on 8/4/21 with a cumulative diagnoses which included Type 2 diabetes. A review of Resident #1's Electronic Medical Record (EMR) revealed a family member was designated as her RP and contact information for the RP was provided in the record. The facility's Medical Director was reported to be Resident #1's physician. The resident's admission Minimum Data Set (MDS) dated 8/11/21 revealed Resident #1 had cognitively intact skills for daily decision making. The physician's orders for Resident #1 included an order dated 8/4/21 which instructed blood glucose testing to be completed before meals and at bedtime each day. The resident's September 2021 Medication Administration Record (MAR) and/or EMR vital sign record revealed Nurse #1 documented she completed a blood glucose check for this resident on 9/27/21 at 9:19 PM and on 9/28/21 at 6:44 AM. Further review of the resident's EMR was conducted on 10/7/21 and included the Progress notes, Assessments, and Documents. No documentation was identified to indicate Resident #1's RP was informed of infection control concerns related to the blood glucose monitoring conducted for this resident on 9/27/21 and	F 580	deficiencies cited have been or will be corrected by the dates indicated. F 580 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 10.07.2021, the responsible parties for each resident (#1, #2, #3, #4, #5 and #6) were notified that the resident had their blood sugar checked using the same glucometer that had not been disinfected with an approved EPA agent between residents. The Director of Nurses (DON) notified the Medical Director of the deficient practice on 09.28.2021. On 09.29.2021 the DON notified the Medical Director of the steps taken to correct the deficient practice. The DON notified the Forsyth County Health Department of the deficient practice and of the steps taken to correct the deficient practice on 09.29.2021. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents who have orders for accuchecks have the potential to be affected. On 09.28.2021 the DON identified 100% of all residents with orders for accuchecks. On, 9.28.2021, the LPN reviewed 100% of all residents identified	

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F 580	Continued From page 3 9/28/21. 1-b) Resident #2 was admitted to the facility on 7/29/20 with a cumulative diagnoses which included Type 2 diabetes. A review of Resident #2's EMR revealed a family member was designated as her RP and contact information for the RP was provided in the record. The facility's Medical Director was reported to be Resident #2's physician. The physician's orders for Resident #2 included an order written on 10/28/20 which instructed blood glucose testing to be completed in the morning every Monday, Wednesday and Friday due to her diagnosis of diabetes. The resident's annual MDS dated 7/6/21 revealed Resident #2 had severely impaired cognitive skills for daily decision making. An interview was conducted with Nurse #1 on 9/28/21 at 6:45 AM after the completion of her scheduled medication pass. During the interview, the nurse identified all the blood glucose checks she had completed earlier that morning while using a shared glucometer. She reported these checks included a blood glucose check for Resident #2 with a result of 160 milligrams (mg) / deciliter (dL). Further review of the resident ' s EMR was conducted on 10/7/21 and included the Progress notes, Assessments, and Documents. No documentation was identified to indicate Resident #2's RP was informed of infection control concerns related to the blood glucose monitoring conducted for this resident on 9/28/21.	F 580	as having orders for accuchecks to ensure that each resident had their own individual glucometer and that they did not have their blood sugar checked with the shared glucometer. No other residents were noted to have had their blood sugar checked on the shared glucometer, no other notifications of change were needed. 3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur: Beginning 10.15.2021, all licensed nurses Registered Nurses and Licensed Practical Nurses full time, part time, prn, and agency staff were educated by the Director of Nursing or designee on the requirement to notify the resident, their responsible party and the MD when there are any significant changes that result in the residents sharing a glucometer and not disinfecting the glucometer with an EPA approved disinfectant placing them at risk for exposure. The DON will ensure that any of the above identified staff who do not complete the in-service training by 10.25.2021 will not be allowed to work until the training is completed. This in-service was incorporated into the new employee facility orientation for the above identified staff. 4. Monitoring Procedure to ensure that	

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F 580	Continued From page 4 1-c) Resident #3 was admitted to the facility on 10/22/19 with a cumulative diagnoses which included Type 2 diabetes. A review of Resident #3's EMR revealed a family member was designated as her RP and contact information for the RP was provided in the record. The facility's Medical Director was reported to be Resident #3's physician. The resident's annual MDS dated 7/28/21 revealed Resident #3 had severely impaired cognitive skills for daily decision making. The physician's orders for Resident #3 included an order dated 10/17/20 which instructed blood glucose testing to be completed before meals and at bedtime each day. The resident's September 2021 MAR and/or EMR vital sign record revealed Nurse #1 documented she completed a blood glucose check for this resident on 9/27/21 at 10:56 PM and on 9/28/21 at 6:13 AM. Further review of the resident's EMR was conducted on 10/7/21 and included the Progress notes, Assessments, and Documents. No documentation was identified to indicate Resident #3's RP was informed of infection control concerns related to the blood glucose monitoring conducted for this resident on 9/27/21 and 9/28/21. 1-d) Resident #4 was admitted to the facility on 4/9/18 with a cumulative diagnoses which included Type 2 diabetes.	F 580	the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Director of Nursing or designee will use the F580 QA Tool audit 5 observations of blood sugar checks per week x 4 weeks and then 5 observations of blood sugar checks per month x 3 months to identify any deficient practice of shared glucometers where the glucometer was not properly disinfected with EPA registered disinfectants and that no notification of change was required. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Nurse, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Plan of Correction Compliance Date: 10.25.2021	

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A review of Resident #4's EMR revealed a family member was designated as her RP and contact information for the RP was provided in the record. The facility's Medical Director was reported to be Resident #4's physician.

The resident's quarterly MDS dated 8/3/21 revealed Resident #4 had cognitively intact skills for daily decision making.

The physician's orders for Resident #4 included an order dated 11/2/20 which instructed blood glucose testing to be completed each morning due to her diagnosis of diabetes.

The resident's September 2021 MAR and/or EMR vital sign record revealed Nurse #1 documented she completed a blood glucose check for this resident on 9/28/21 at 6:06 AM.

Further review of the resident's EMR was conducted on 10/7/21 and included the Progress notes, Assessments, and Documents. No documentation was identified to indicate Resident #4's RP was informed of infection control concerns related to the blood glucose monitoring conducted for this resident on 9/28/21.

1-e) Resident #5 was admitted to the facility on 8/19/21 with a cumulative diagnoses which included Type 2 diabetes.

A review of Resident #5's EMR revealed a family member was designated as her RP and contact information for the RP was provided in the record. The facility's Medical Director was reported to be Resident #5's physician.

The resident's admission MDS dated 8/24/21

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F 580	Continued From page 6	F 580		

revealed Resident #5 had cognitively intact skills for daily decision making.

The physician's orders for Resident #5 included an order dated 8/27/21 which instructed blood glucose testing to be completed before meals and at bedtime each day.

The resident's EMR vital sign record revealed Nurse #1 documented she completed a blood glucose check for this resident on 9/27/21 at 11:12 PM.

An interview was conducted with Nurse #1 on 9/28/21 at 6:45 AM after the completion of her scheduled medication pass. During the interview, the nurse identified all the blood glucose checks she had completed earlier that morning while using a shared glucometer. These checks included a blood glucose check for Resident #5 with a result of 201 mg/dL.

Further review of the resident's EMR was conducted on 10/7/21 and included the Progress notes, Assessments, and Documents. No documentation was identified to indicate Resident #5's RP was informed of infection control concerns related to the blood glucose monitoring for this resident on 9/27/21 and 9/28/21.

1-f) Resident #6 was admitted to the facility on 12/28/18 with a cumulative diagnoses which included Type 2 diabetes.

A review of Resident #6's EMR revealed the resident was her own RP. The facility's Medical Director was reported to be Resident #6's physician.

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F 580	Continued From page 7	F 580		

The resident's quarterly MDS dated 8/9/21 revealed Resident #6 had cognitively intact skills for daily decision making.

The physician's orders for Resident #6 included an order dated 10/21/20 which instructed blood glucose testing to be completed once daily at 6:45 AM as well as before meals and at bedtime each day.

The resident ' s September 2021 MAR and/or EMR vital sign record revealed Nurse #1 documented she completed a blood glucose check for this resident on 9/27/21 at 11:07 PM and on 9/28/21 at 5:56 AM.

Further review of the resident's EMR was conducted on 10/7/21 and included the Progress notes, Assessments, and Documents. No documentation was identified to indicate Resident #6 was informed of infection control concerns related to the blood glucose monitoring conducted for her on 9/27/21 and 9/28/21.

A telephone interview was conducted on 10/7/21 at 2:38 PM with the facility's Director of Nursing (DON). During the interview, the reported the Medical Director was informed of the infection control concerns related to the blood glucose monitoring for the six residents when immediate jeopardy was identified on 9/29/21. She confirmed physician orders were received and implemented to complete vital sign checks every shift for each of the residents involved.

As the telephone interview continued on 10/7/21 at 2:38 PM, the DON was asked what circumstances would prompt the facility to notify a resident's RP. She reported the RP would

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F 580	Continued From page 8 normally be contacted if a resident had a change in condition or medications and documentation of this notification would typically be noted on a Change of Condition Assessment or in a Progress Note within the resident's EMR. The DON was also asked whether the RPs had been notified for the 6 residents identified with infection control concerns related to the blood glucose monitoring conducted on 9/27/21 and 9/28/21. The DON reported the residents' RPs had not been notified.	F 580		
F 835 SS=K	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to provide orientation and education to nursing staff on the availability of individual blood glucose monitors (glucometers) assigned to each resident requiring blood glucose monitoring. The facility also failed to provide education on how to disinfect a shared glucometer used for multiple residents in accordance with the manufacturer's instructions. This was evident for 1 of 1 nurse (Nurse #1) observed who was new to the facility and worked independently as a hall nurse assigned to care for residents. Immediate jeopardy began on 9/27/21 when Nurse #1 (an Agency nurse) did not receive an	F 835	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 835 1. How corrective action will be accomplished for those residents found to have been affected by the deficient	10/22/21

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F 835	Continued From page 9 orientation to the facility and began blood glucose testing for 6 residents on her assigned hall using a shared glucometer without cleaning the glucometer between residents with an Environmental Protection Agency (EPA)-registered disinfectant. Immediate jeopardy was removed on 9/30/21 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of E (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete facility employee and Agency staff in-service orientation and training. The findings included: This tag is cross referenced to: F880 - Based on observations, staff interviews, and record review, the facility failed to use an approved disinfectant product and procedure to clean and disinfect a shared blood glucose meter (glucometer) used for 6 of 6 residents required to have their blood glucose checked (Resident #1, #2, #3, #4, #5 and #6). Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an EPA-approved disinfectant in accordance with the manufacturer of the glucometer potentially exposes residents to the spread of blood borne infections. An interview was conducted on 9/29/21 at 10:45 AM with the facility's Scheduler. The Scheduler reported she was responsible for scheduling both nurses and nursing assistants. While the facility employed some of their nursing staff, the	F 835	practice: Nurse #1 was educated by the Licensed Professional Unit Support Nurse on the facility□s glucometer policy on 09.28.2021. Nurse #1 has not worked at the facility since 09.28.2021. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents who have orders for accuchecks have the potential to be affected. On 9.29.2021, the scheduler reviewed the schedule for the next 7 days and identified different agency nurses or medication aides that are already scheduled to work. The Director of Nurses and Assistant Director of Nurses (ADON), reached out to the nurses who were scheduled to work to provide them with the agency orientation packets that includes glucometer training and the importance of using a resident□s individually assigned glucometer and the need to disinfect using an EPA registered chemical. 100% of all agency nurses that were scheduled to work 09.29.2021 have been educated utilizing the agency orientation packet. No agency staff member will be allowed to work after 09.29.2021 until the agency orientation packet has been completed. 3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur:	

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F 835	Continued From page 10 Scheduler reported she utilized five temporary staffing agencies to help meet the staffing needs of the facility on an as needed basis. An interview was conducted on 9/29/21 at 11:35 AM with the facility's Director of Nursing (DON). The DON was asked about the orientation process utilized for both staff and Agency nurses. She reported the facility had a form she used to orient Agency nurses. The DON stated she herself tried to complete this orientation on the first day a new Agency nurse came in prior to the start of his/her shift. If she was not able to conduct the orientation, one of her staff nurses or a Unit Manager would go over the form with the new nurse. The DON reported Nurse #1 was, "a last minute fill-in for the shift" and she had not been made aware this Agency nurse was coming in to work her first shift at the facility. A review of the form entitled, "Agency Nurse and Nursing Student Orientation" was conducted. The form included content on each of the following topics: Medication Administration; Treatments; Emergency Situations; Documentation; Falls; Elopement; Restraints; Injuries of Unknown Origin and Abuse Prevention/Investigation; Pressure Ulcers; Medications; and Personal Protective Equipment. Neither blood glucose monitoring nor the disinfection of glucometers were included on this form. A follow-up interview was conducted on 9/29/21 at 12:04 PM with the DON in the presence of the facility's Quality Assurance (QA) Clinical Consultant. When asked, the DON reported the outline provided would typically have been completed for each Agency nurse prior to the	F 835	On 09.29.2021, the Director of Nurses (DON), Assistant Director of Nurses (ADON), LPN Unit Support Nurse, the Human Resources staff member, and facility scheduler were educated by the Quality Assurance Nurse Consultant on the importance for ensuring that all agency staff receive the orientation packet prior to the beginning of their shift. The scheduler and/or Human Resources staff or designee will print agency orientation education packets for agency nurses that have not previously been oriented using the agency education packet. These packets will be placed in the copy room in a designated box with the agency nurses name for review and signature at the beginning of their shift. The scheduler will notify the agency nurses who are scheduled for future dates that the packets are located in the designated box in the copy room and that they should be signed and placed under the Director of Nurses door, which is located across the hall from the copy room once completed. The scheduler will also provide a list of new agency staff to the Director of Nurses and the facility on-call nurse weekly. The Director of Nurses or designee will ensure that all agency staff are educated using the agency orientation packet. Any emergency as needed agency staff are scheduled and approved by the Director of Nurses, Assistant Director of Nurses, or LPN (Licensed Professional Nurse) Unit Support Nurse. Additional orientation packets will be placed in the designated	

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SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

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start of his/her first shift. However, she confirmed Nurse #1 did not receive the orientation as outlined on this form.

A second follow-up interview was conducted on 9/30/21 at 11:45 AM with the facility's DON. During the interview, the DON reported she would expect all of the facility's staff nurses to complete an orientation prior to working independently on the residents' halls. The DON also stated she would expect to be notified if a new Agency nurse was going to be coming in to work at the facility so either the DON or a designated staff member could talk with the nurse to review the facility's orientation packet.

On 9/29/21 at 1:30 PM, the facility's Regional Vice President, QA Clinical Consultant, and DON were informed of the immediate jeopardy.

The facility provided a credible allegation of Immediate Jeopardy removal on 9/29/21 at 7:40 PM. The allegation of immediate jeopardy removal indicated:

The facility failed to provide orientation and education to Nurse #1 (an Agency nurse) on the availability of individual glucometers assigned to each resident requiring blood glucose monitoring. The facility also failed to educate Nurse #1 on how to disinfect a shared glucometer according to manufacturer's instructions when used for multiple residents.

Component 1: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and

On 9/28/21 residents #1, #2, #3, #4, #5, and #6

box in the copy room. Anytime a new agency person is sent to the facility the on-call nurse will contact them by phone and will ensure that they retrieve, review and sign the agency orientation packet.

The DON will ensure that any of the above identified staff who do not complete the in-service training by 10.22.2021 will not be allowed to work until the training is completed.

This in-service was incorporated into the new employee facility orientation for the above identified staff.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements:

The Director of Nurses or designee will monitor for compliance by auditing the schedule to ensure all agency staff scheduled have a signed orientation packet completed and on file. The Director of Nurses or designee will complete the audit weekly x 4 weeks and monthly x 3 months. Results will be documented on the F835 Quality Assurance Tool. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality

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F 835	Continued From page 12 had their blood sugar checked using the same glucometer that had not been disinfected with an approved EPA agent between residents. Once the facility was notified of the deficient practice, the Licensed Practical Nurse Unit Support Nurse (LPN) promptly removed the glucometer from the cart. The LPN Unit Support Nurse checked each medication cart to ensure there were no glucometers on the cart. No glucometers were found on the cart. Additionally, on 9/28/21 the LPN verified that each resident (#1, #2, #3, #4, #5, and #6) had their own individual glucometer in their room. If a new admission comes in and needs an individual glucometer, the cleaned and sanitized glucometers are located in the unit medication rooms. Additionally, on 9/29/21, the scheduler reviewed the schedule for the next 7 days and identified different agency nurses or medication aides that are already scheduled to work. The DON, ADON, has reached out to these nurses to provide them with the orientation packets that includes the importance of using a resident's individually assigned glucometer and the need to disinfect using an EPA registered chemical. 100% of all agency nurses that are scheduled for 9/29/21 have been educated utilizing agency orientation packet including the importance of using a resident's individually assigned glucometer and the need to disinfect using an EPA registered chemical. The orientation material will have a copy of the Manufacturer's instructions that have the cleaning and disinfecting procedures for glucometers. No agency staff member will be allowed to work until this education is provided. Component 2: Specify the action the entity will	F 835	Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Nurse, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Compliance Date: 10.22.2021	

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take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 9/29/21, the Director of Nurses (DON), Assistant Director of Nurses (ADON), LPN Unit Support Nurses, the HR staff member, and scheduler were educated by the Quality Assurance Nurse Consultant on the importance for ensuring that all agency staff receive the orientation packet prior to the beginning of their shift. The scheduler and/or HR staff will print education packets for agency nurses that have not previously been oriented using the education packet. These packets will be placed in the copy room in a designated box with the agency nurses name for review and signature at the beginning of their shift. The scheduler will notify the agency nurses who are scheduled for future dates that the packets are located in the designated box in the copy room and that they should be signed and placed under the DON's door, which is located across the hall from the copy room once completed.

The scheduler will also provide a list of new agency staff to the facility on-call nurse each day. To ensure that this occurs, the facility on-call nurse will call the facility and talk to the agency staff member to ensure that the education packet was reviewed and signed and will address any questions that they may have.

As needed agency staff are scheduled and approved by the DON, ADON, or LPN Unit Support Nurse. Additional orientation packets will be placed in the designated box in the copy room. Anytime a new agency person is sent to the

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F 835	Continued From page 14 facility the on-call nurse will contact them by phone and will ensure that they retrieve, review and sign the orientation packet. Component 3: Date of completion 9/30/21 On 9/30/21 from 8:02 AM through 12:15 PM, interviews were conducted with facility staff during the validation process. During an interview, the facility's Scheduler described her role in identifying when a new Agency nurse was coming to work in the facility. The Scheduler reported she was always told in advance by the temporary staffing Agency the name of the nurse who would be assigned to work a shift. She stated anytime a new Agency nurse picked up a shift at the facility, she would notify the DON and ADON. When asked, the Scheduler reported the administrative staff would be notified even if there was a last minute change in Agency nurses assigned to work at the facility. Interviews were conducted with both the DON and ADON with regards to the process of orientation for facility staff and Agency nurses. The DON and ADON confirmed they were also doing a "double check" of the next day's nursing staff schedule to ensure orientation and education (including infection control protocols for blood glucose monitoring) were provided to nurses before starting work at the facility. Based on the staff interviews, the credible allegation was validated and the immediate jeopardy was removed on 9/30/21.	F 835		
F 880 SS=K	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	F 880		10/22/21

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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 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

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F 880	Continued From page 16 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 observations, staff interviews, and record review, the facility staff failed to use an approved disinfectant product and procedure to clean and disinfect a shared blood glucose meter (glucometer) used for 6 of 6 residents (Resident #1, #2, #3, #4, #5 and #6). Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-approved disinfectant in accordance with the manufacturer of the glucometer potentially exposes residents to the spread of blood borne infections.	F 880	F880 Infection Control Plan of Correction and Directed Plan of Correction The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	

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F 880	Continued From page 17 Immediate Jeopardy began on 9/27/21 when Nurse #1 (an Agency nurse new to the facility) began performing blood glucose testing for 6 residents on her assigned hall using a shared glucometer. Nurse #1 did not disinfect the shared glucometer between residents using an EPA-registered disinfectant. In addition, Nurse #1 was not aware facility residents each had their own individual glucometer stored in a plastic, covered container in his/her room. Immediate Jeopardy was removed on 9/30/21 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of E (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training. The findings included: A review of the facility policy entitled "Glucometers" (Originated January 2011; Last Revised January 2011) read, in part: "It is the policy of this facility to utilize individual glucometers for each resident." The topic of "Cleaning" read: "Anytime the glucometer is visibly soiled and PRN (as needed), it will be cleaned and disinfected per Manufacturer's guidelines." The manufacturer instructions for the glucometer used at the facility instructed the cleaning and disinfection procedure should be performed as recommended to minimize the risk of transmitting blood-borne pathogens. These instructions read in part, "The meter should be cleaned and disinfected after use on each patient. The (Brand	F 880	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 09.28.2021, it was discovered that resident #1, #2, #3, 4#, 5# and #6 had their blood sugar checked using the same glucometer that had not been disinfected with an approved EPA agent between residents. Once the facility was notified of the deficient practice, the Licensed Practical Nurse Unit Support Nurse (LPN) promptly removed the glucometer from the cart. On 09.28.2021, the LPN Unit Support Nurse checked each medication cart to ensure there were no glucometers on the cart. No glucometers were found on the cart. Additionally, on 09.28.2021 the LPN verified that each resident (#1, #2, #3, #4, #5, #6) had their own individual glucometer in their room. The Director of Nurses (DON) notified the Medical Director of the deficient practice on 09.28.2021. On 09.29.2021 the DON notified the Medical Director of the steps taken to correct the deficient practice including ensuring that each resident had their own individual glucometer and that the nurses were educated on proper steps to take for disinfecting the glucometers. On 09.29.2021, the Medical Director ordered vital sign monitoring for 72 hours for resident #1, #2, #3, 4#, 5# and #6. The DON notified the Forsyth County Health Department of the deficient practice on 09.29.2021. The Health	

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F 880	Continued From page 18 Name) multi Blood Glucose Monitoring System may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed." The Cleaning and Disinfection instructions read, "The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfection procedure. The disinfection procedure is needed to prevent the transmission of blood-borne pathogens. A variety of the most commonly used EPA-registered wipes have been tested and approved for cleaning and disinfecting of the (Brand Name) multi Blood Glucose Monitoring System." The instructions provided a list of disinfectant wipes which were shown to be safe for use with the glucometer. This list did not include alcohol wipes. A medication administration observation was initiated on 9/28/21 at 6:23 AM with Nurse #1. Nurse #1 was identified as an Agency nurse (temporary staff) who was assigned to care for residents on the 200 Hall from 7:00 PM on 9/27/21 to 7:00 AM on 9/28/21. The nurse reported she was new to the facility. Nurse #1 was observed on 9/28/21 at 6:34 AM as she picked up a glucometer stored on top of the medication cart and collected supplies to complete a blood glucose check for Resident #1. The nurse then donned gloves and entered Resident #1's room with the testing equipment. After checking the resident's blood glucose, Nurse #1 returned to the medication cart and was observed as she used an alcohol wipe to wipe off the glucometer. She placed the glucometer back on top of the medication cart. Nurse #1 was observed as she completed the medication pass. When asked, Nurse #1 stated she had completed	F 880	Department was also made aware of the interventions that facility put into place to include ensuring that each resident had their own individual glucometer and that the nurses were educated on proper steps to take for disinfecting the glucometers. The Forsyth County Health Department recommended review of the medical diagnosis of resident #1, #2, #3, 4#, 5# and #6 to identify any resident who had any diagnosis related to a Blood Borne Pathogen (BBP). There were no residents who were identified to have any BBP diseases. The DON initiated and completed this review on 10.08.2021. Additionally, the Forsyth County Health Department reviewed education with the facility via a phone call on 10.08.2021. The DON and Administrator attended the education. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents who have orders for accuchecks have the potential to be affected. On 09.28.2021 the DON identified 100% of all residents with orders for accuchecks. The LPN reviewed 100% of all residents identified as having orders for accuchecks to ensure that each resident had their own individual glucometer. The review was completed on 09.28.2021. Results: all residents had their own individual glucometer. Additionally, on 09.28.2021 □ 09.30.2021,	

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F 880	Continued From page 19 all of the other blood glucose checks scheduled on her assigned hall. Upon further inquiry, the nurse identified the other blood glucose checks she had already completed earlier that morning. These checks included Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6. As the interview with Nurse #1 continued, the nurse was asked if the glucometer observed to be used for Resident #1 was a shared meter used for all five of the other named residents. Nurse #1 reported it was and stated she "assumed" the facility used a shared glucometer for residents because it was the only glucometer she had seen. Upon further inquiry, the nurse was asked how she disinfected the meter between the residents. Nurse #1 reported she used an alcohol wipe as was previously observed to clean the shared glucometer between residents. Nurse #1 was also asked if there were any disinfectant wipes available on the medication cart specifically intended to clean and disinfect a glucometer. She stated she did not know. Upon request, Nurse #1 was observed as she opened the bottom drawers of the medication cart; no EPA-approved disinfectant wipes were observed to be stored on the med cart. An interview was conducted on 9/28/21 at 6:47 AM with the facility's night shift nurse supervisor. At that time, concerns regarding the use of a shared glucometer and failure to disinfect the glucometer between residents with an approved disinfectant were discussed. The nurse supervisor reported a shared glucometer would need to be disinfected using (Brand Name) disinfectant wipes. However, she reported each resident had an individual glucometer and she proceeded to point out where the glucometer would be stored in each of the residents' rooms.	F 880	the DON or designee completed daily audits to check the medication carts to ensure there were no glucometers on the cart. Results: No glucometers were found on the cart. 3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur: On 09.28.2021, the DON and the Quality Assurance Nurse Consultant reviewed the glucometer policy. There were no revisions to the policy required. LTC Infection Control Self-Assessment: On 10.21.2021, the LTC Infection Control Assessment was completed by the: DON, Infection Preventionist, Assistant Director of Nurses (ADON), LPN Unit Support Nurse, Regional Clinical Consultant and the Contracted Consultant. The LTC Infection Self-Assessment was then discussed with and sent to the Medical Director for review on 10.21.2021. Root Cause Analysis: On 09.29.2021, the Director of Nurses, Assistant Director of Nurses, Administrator, Regional Director of Operations, Quality Assurance Nurse Consultant, LPN Unit Support Nurse, conducted a root cause analysis and determined that the root cause of the deficient practice was that the scheduler didn□t notify the facility on call nurse that the agency nurse would be working and the required agency orientation would need to be completed. Therefore,	

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F 880	Continued From page 20 The nurse supervisor reported all individual glucometers were thoroughly disinfected and calibrated once a week. A review of each residents' electronic medical record revealed the following information: --In addition to the blood glucose level observed to be checked by Nurse #1 on the morning of 9/28/21, Resident #1 also had her blood glucose documented as checked by Nurse #1 on 9/27/21 at 9:19 PM. --Resident #2 did not have any additional blood glucose results documented as checked by Nurse #1. -- In addition to the blood glucose level checked the morning of 9/28/21, Resident #3 also had her blood glucose documented as checked by Nurse #1 on 9/27/21 at 10:56 PM. -- Resident #4 did not have any additional blood glucose results documented as checked by Nurse #1. -- In addition to the blood glucose level checked the morning of 9/28/21, Resident #5 also had her blood glucose documented as checked by Nurse #1 on 9/27/21 at 11:12 PM. -- In addition to the blood glucose level checked the morning of 9/28/21, Resident #6 also had her blood glucose documented as checked by Nurse #1 on 9/27/21 at 11:07 PM. An interview was conducted with the facility's Administrator, Director of Nursing (DON), and Quality Assurance (QA) Clinical Consultant on 9/28/21 at 1:55 PM. During the interview, the infection control concerns related to Nurse #1's failure to use residents' individually assigned glucometers and her failure to use an approved disinfectant on the shared glucometer used for 6 residents were discussed. The DON reported	F 880	Nurse#1 was not aware that each resident had their own individual glucometer or of the facility glucometer disinfecting procedure. On 09.29.2021, the Quality Assurance and Process Improvement Committee met to discuss and review root cause analysis. On 10.21.2021, the contracted Nurse Consultant reviewed the root cause analysis. This root cause analysis was incorporated into the plan of correction/intervention plan. Contacted Consultant: Facility has contracted with a Consultant who has completed specialized training in Infection Prevention and Control effective date 10.21.2021 for a duration 6 months to assist in 1) in-services specific to the issues cited if needed 2) assist with root cause analysis 3) assist with development of the plan of correction 4) assist with development/review of the facility Infection Control assessment 5) routine visits to assist with monitoring infection prevention/control practices 6) written report with findings, recommendations if any will be provided following each visit. Education: On 09.28.2021, the Director of Nurses (DON) and Assistant Director of Nurses (ADON) began reeducating all licensed nurses and medication aides full time, part time, and PRN including agency staff on the glucometer policy to include the following topics: " Residents must have their own individual glucometer. " Glucometers must be cleaned and disinfected per Manufacturer□s	

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F 880	Continued From page 21 Nurse #1 was in-serviced after the infection control concerns were identified the morning of 9/28/21 regarding the need to use each resident ' s individually-assigned glucometer and use of an approved disinfectant to clean/disinfectant a glucometer. An interview was conducted on 9/30/21 at 11:00 AM with the facility's Assistant Director of Nursing (ADON). During the interview, the ADON reported only nurses and facility staff medication aides conducted blood glucose monitoring for residents. She also reported an audit of the facility's medication carts was conducted after the infection control concerns were identified on 9/28/21. This audit revealed the 200 Hall med cart (the med cart observed to be used by Nurse #1 on 9/28/21) did not contain an EPA-approved disinfectant product intended for use on glucometers. A follow-up interview was conducted on 9/30/21 at 11:45 AM with the facility's DON. During the interview, the DON reported she would expect all nurses to check residents ' blood glucose levels in accordance with physician's orders and to follow "proper protocols." She reported a glucometer was kept in each resident's room with the intent for it to be used only for that resident. The DON also stated each glucometer needed to be cleaned and disinfected as needed. If any staff member had questions with regards to blood glucose monitoring or the use of a glucometer, he/she needed to reach out to a Unit Manager, ADON, or the DON for guidance. On 9/29/21 at 1:30 PM, the facility's Regional Vice President, QA Clinical Consultant, and Director of Nursing were informed of the	F 880	recommendations when visibly soiled and PRN. The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfection procedure. The disinfection procedure is needed to prevent the transmission of blood-borne pathogens. " The sanitizing wipes for cleaning and disinfecting are located in the unit medication rooms and the supply room. " Sanitized and cleaned glucometers are located in the unit medication rooms or the supply room. " The glucometer orientation material is included in the agency orientation education packet. On 09.29.2021, the DON and ADON completed return demonstration for 100% of licensed nurses and medication aides to ensure they were aware of the correct procedure to clean and disinfect the glucometers. As of 09.29.2021, 100% of all nurses and medication aides have completed return demonstrations. There were no issues identified with the return demonstrations. The DON will ensure that any of the above identified staff who do not complete the in-service training by 09.29.2021 will not be allowed to work until the training is completed. This in-service was incorporated into the new employee facility orientation for the above identified staff.	

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	345039	A. BUILDING _____ B. WING _____	C 10/08/2021

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F 880	Continued From page 22 immediate jeopardy. The facility provided a credible allegation of Immediate Jeopardy removal on 9/29/21 at 7:50 PM. The allegation of immediate jeopardy removal indicated: Credible Allegation of Immediate Jeopardy Removal: The facility failed to use an approved disinfectant product and procedure to clean and disinfect a shared glucometer used for 6 residents required to have their blood glucose checked (Resident #1, #2, #3, #4, #5 and #6). Nurse #1 (an Agency nurse) who performed the blood glucose testing was not aware facility residents each had their own individual blood glucose meter stored in a plastic, covered container in his/her room. Nurse #1 was also not trained on how to disinfect a shared glucometer according to manufacturer's instructions when used for multiple residents. Component 1: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and On 9/28/21, it was discovered that resident #1, #2, #3, 4#, 5# and #6 had their blood sugar checked using the same glucometer that had not been disinfected with an approved EPA agent between residents. Once the facility was notified of the deficient practice, the Licensed Practical Nurse Unit Support Nurse (LPN) promptly removed the glucometer from the cart. On 9/28/21, the LPN Unit Support Nurse checked each medication cart to ensure there were no glucometers on the cart. No glucometers were found on the cart. Additionally, on 9/28/21 the	F 880	4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Director of Nursing or designee will monitor for compliance by observing blood sugar checks to ensure staff use the resident□s individual glucometer and that the glucometers are cleaned according to manufacturer guidelines. The Director of Nursing or designee will audit 5 observations of blood sugar checks per week x 4 weeks and then 5 observations of blood sugar checks per month x 3 months. Results will be documented on the F880 Quality Assurance Tool. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until resolved by the QA Committee. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Nurse, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Directed Plan of Correction Compliance Date: 10.22.2021 Compliance Date: 10.22.2021	

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LPN verified that each resident (#1, #2, #3, #4, #5, #6) had their own individual glucometer in their room.

The Director of Nurses interviewed the nurses and there were no other residents who were identified as being impacted by the deficient practice.

Component 2: Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 9/29/21, the Director Nurses, Assistant Director of Nurses, Administrator, Regional Director of Operations, Quality Assurance Nurse Consultant, LPN Unit Support Nurse, conducted a root cause analysis and determined that the root cause of the deficient practice was that the scheduler didn't notify the facility on call nurse that the agency nurse would be working and required agency orientation to be completed and Nurse#1 was not aware that each resident had their own individual glucometer or of the facility glucometer disinfecting procedure. On 9/29/21, the QAPI Committee met to discuss and review root cause of analysis. The Medical Director and the Forsyth County Health Department were made aware of the deficient practice and the steps to correct the deficient practice on 9/29/21. The Forsyth County Medical Director and the Medical Director were both informed on 9/29/21 of the interventions that facility had put into place to include ensuring that each resident had their own individual glucometer and that the nurses were educated on proper steps to take for disinfecting the glucometers. There were no

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further recommendations from the Health Department or the Medical Director. The facility did request orders to obtain vital sign monitoring for next 72 hours for each resident.

On 9/28/21, the Director of Nurses (DON) and Assistant Director of Nurses (ADON) began educating all licensed nurses and medication aides full time, part time, and PRN including agency staff on the glucometer policy to include the following:

· Residents must have their own individual glucometer.
· Glucometers must be cleaned and disinfected per Manufacturer ' s recommendations when visibly soiled and PRN. "The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfection procedure. The disinfection procedure is needed to prevent the transmission of blood-borne pathogens."
· The sanitizing wipes for cleaning and disinfecting are located in the unit medication rooms and the supply room.
· Sanitized and cleaned glucometers are located in the unit medication rooms or the supply room.
· The orientation material is included in the agency orientation education packet.

On 9/29/21, the DON and ADON completed QA monitoring to check each medication cart to ensure there were no glucometers on the cart and that each nurse could complete a return demonstration of how to clean and disinfect the glucometers. As of 9/29/21, 100% of all nurses and medication aides have completed return

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demonstrations. There were no issues identified with the return demonstrations.

As of 9/29/21 3pm, any employee who has not received this training will not be allowed to work until the training has been completed. This includes full time, part time, and agency staff. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained.

Component 3: Date of completion 9/30/21

On 9/30/21 from 8:02 AM through 12:15 PM, observations and/or interviews were conducted with staff and Agency nurses assigned to each of the 4 halls within the facility with regards to required infection control practices using glucometers for blood glucose checks. All nurses were aware of the facility's policy to use individually assigned glucometers for each resident requiring blood glucose monitoring and to store the individual glucometer in each resident's room. The location of EPA-approved disinfectant wipes for the cleaning and disinfection of glucometers (as needed) was also observed and discussed with each nurse. Each hall nurse was able to demonstrate and/or verbalize the instructions provided through the in-servicing received on 9/29/21 regarding these infection control practices and the glucometer's manufacturer recommendations for cleaning and disinfection. Based on the observations, staff interviews and a review of the facility's records, the credible allegation was validated and the immediate jeopardy was removed on 9/30/21.

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