STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345555	A. BUILDING _____ B. WING _____	C 12/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST RALEIGH AT CRABTREE VALLEY	3830 BLUE RIDGE ROAD RALEIGH, NC 27612

(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 and complaint investigation survey was conducted on 12/11/2023 through 12/15/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #L45311.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint survey were conducted from 12/11/23 through 12/15/23. The following intakes were investigated NC00199429, NC00200284, NC0019722, NC00198495, NC00199170, NC00206652, and NC00210224, One of the 31 complaint allegations resulted in deficiency. Immediate jeopardy was identified at CFR 483.80 at tag F880 at a scope and severity J. Immediate jeopardy began on 12/13/23 and was removed on 12/15/23.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to determine whether the self-administration of medications was clinically appropriate for 1 of 1 sampled resident (Resident #44) who was	F 554	This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the plan of correction is not an admission that a deficiency exists or that	1/7/24

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

Electronically Signed | 01/04/2024

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F 554	Continued From page 1 observed to have medications at bedside. The findings included: Resident #44 was admitted to the facility on 3/14/20. His cumulative diagnoses included diabetes and polyneuropathy (a condition where multiple nerves located outside of the brain and spinal cord are damaged), and dry eye syndrome. The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 10/3/23. The MDS assessment revealed Resident #44 had intact cognition. A review of Resident #44's current care plan (revised 10/4/23) revealed the resident was not care planned for the self-administration of medications. A review of the resident's electronic medical record (EMR) revealed no physician orders were received for the resident to self-administer any medications. Further review of the EMR revealed there was no documentation of a medication self-administration assessment having been completed for this resident. An observation was conducted on 12/11/23 at 9:55 AM with Resident #44 as he was lying in bed with his bedside tray table placed in front of him. At that time, a bottle of (Brand Name) 4% lidocaine cream and (Brand Name) eye drops were observed to be placed on the bedside tray table within the resident's reach. A second observation was conducted on 12/11/23 at 4:15 PM of Resident #44 as he laid in bed. The observation revealed a bottle of (Brand	F 554	one was cited correctly. The plan of correction is submitted to meet requirements established by state and federal law. [F 554] It is the policy of Hillcrest Raleigh at Crabtree Valley (Hillcrest) to comply with the right to self-administer medications if the interdisciplinary team has determined that this practice is appropriate; Resident Self-Administration Meds Clinically Appropriate. Address how the corrective action will be accomplished for those residents found to have been affected by deficient practice; 1. Medications were removed from resident #44 room by RN Supervisor on 12/12/2023. On 12/12/2023, RN supervisor educated resident #44 on the self-administration policy. On 12/12/2023, RN supervisor and medication nurse called responsible party and educated him on self-administration policy. Resident #44 was offered self-administration opportunity to which he refused. Address how the facility will identify other residents having the potential to affected by the deficient practice; 1. On 12/12/2023, nursing staff checked all resident rooms to ensure no other OTC medications were observed at bedside. 2. On 12/13/2023, the DON/ designee in-serviced all nursing staff and med aides on the facilities self-administration processes, to include written telephone orders and self-administration	

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F 554	Continued From page 2 Name) 4% lidocaine cream and (Brand Name) eye drops remained on the resident's bedside tray table and within his reach. An observation and interview was conducted with Resident #44 on 12/12/23 at 9:35 AM. The resident was observed to be lying in his bed. He was awake and alert. The observation revealed a bottle of (Brand Name) 4% lidocaine cream, (Brand Name) eye drops, and a bottle of fungicide for nails were placed on the resident's bedside tray table in front of him and within his reach. Upon inquiry, the resident reported it was difficult for him to put the eye drops in his eyes by himself "most of the time," so the nurse would occasionally come by and take care of it for him. When asked about the 4% lidocaine cream, the resident reported staff would apply this to his "butt" when he asked them to. Additionally, an inquiry was made regarding the bottle of fungicide for nails observed at bedside. The resident reported he used this topical treatment on his fingernails himself. Accompanied by the Registered Nurse (RN) Supervisor, an observation was conducted on 12/12/23 at 5:13 PM of Resident #44 as he laid in his bed and of the resident's medications (4% lidocaine cream, eye drops, and fungicide for nails) still placed on his bedside tray table. The RN Supervisor was observed as she asked Resident #44 if he applied these medications (meds) himself. He stated he administered both his eye drops and the lidocaine to himself "once in a while." Upon leaving the room, the RN Supervisor stated she did not notice the bottle of fungicide for nails on Resident #44's bedside table so did not specifically ask about it. The RN Supervisor was accompanied as she went to the	F 554	assessment form, and confirming the existence of same, if medication is observed in resident's room. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; 1. On 01/04/2024 the DON/ designee posted signage in common areas to make residents/responsible parties aware of OTC self-administration processes. 2. The facility will include OTC self-administration processes information in the residents' admission packet starting on 01/05/2024, to clearly communicate the importance of consulting with facility staff before introducing OTC medications at bedside. 3. The Executive Director/ designee will include OTC self-administration processes information in the next facility newsletter. 4. The DON/ designee will conduct random audits on at minimum 5 rooms per unit to ensure that OTC medications are not present unless self-administration procedures are in place with audits weekly x 4 weeks and bi-weekly x 2 months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; 1. This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting. The Committee will review audits to ensure compliance and determine if additional audits or training	

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F 554	Continued From page 3	F 554		

nurses' station and reviewed the resident's paper medical record. Upon review of this record, she reported Resident #44 did not have a physician's order for these medications or an order allowing the resident to self-administer them. Additionally, the RN Supervisor noted the self-administration of medications were not care planned for Resident #44 and he did not have a "waiver" for the self-administration of medications in his paper chart. The RN Supervisor stated, "They (the medications) shouldn't be at bedside." When asked what the facility's process involved related to a resident self-administering medications, the RN Supervisor reported the resident first needed to be assessed to determine if he/she was able to self-administer the medications. Once it was determined the resident could safely administer the medications, he/she would need to sign a waiver. The facility would need to obtain a physician's order for the medications as well as the self-administration of them. Also, the self-administration of meds needed to be care planned for the resident.

A follow-up interview was conducted on 12/13/23 at 9:52 AM with the RN Supervisor. During the interview, the RN Supervisor reported it was determined that Resident #44 should not self-administer the medications observed to be at bedside, so they were removed from his room.

An interview was conducted on 12/14/23 at 4:47 PM with the facility's Director of Nursing (DON). During this interview, the DON reported the facility had a process that needed to be followed to be sure it was safe for a resident to self-administer his/her medications. She stated if assessment of the resident showed he/she was able to safely self-administer a medication, the

are necessary.

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F 554	Continued From page 4 facility would need to obtain a physician's order for the self-administration of medications and would need to include it in the resident's care plan. The DON also reported the facility would need to provide a lock box to securely store any medications kept in the resident's room. She reported having a discussion with Resident #44 to ensure his current needs were being met with the medications ordered. She stated the resident told her he just thought it would be nice to have the medications "in case of an emergency." The DON reported Resident #44 did not mind if the medications were removed from his room.	F 554		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 578		1/7/24

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F 578	Continued From page 5 (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain accurate advanced directive (code status) information throughout the medical record for 1 of 29 residents reviewed for advanced directives (Resident #9). The findings included: Resident #9 was admitted to the facility on 2/15/23. The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 11/10/23. A review of the MDS assessment revealed Resident #9 was cognitively intact. A review of Resident #9's electronic medical record (EMR) was conducted on 12/12/23. The banner at the top of Resident #9's EMR page indicated the resident had an advanced directive	F 578	This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the plan of correction is not an admission that a deficiency exists or that one was cited correctly. The plan of correction is submitted to meet requirements established by state and federal law. [F 578] It is the policy of Hillcrest Raleigh at Crabtree Valley (Hillcrest) to comply with F578 request/refuse/discontinue treatment; advanced directives Address how the corrective action will be accomplished for those residents found to have been affected by deficient practice; 1. On 12/14/2023, the Director of Nursing	

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F 578	Continued From page 6 which indicated "DNR" (Do Not Resuscitate). However, a review of the resident's paper medical record revealed it did not include a signed DNR advanced directive. On 12/12/23 at 3:10 PM, an interview was conducted with the facility's Registered Nurse (RN) Supervisor. Upon review of Resident #9's paper medical record, the RN Supervisor reported there was not a "golden rod" (referring to a deep yellow paper) advance directive for a DNR code status in her paper chart. She reported if a golden rod advance directive for DNR status was not in the paper chart, it indicated the resident was a full code. The RN Supervisor reported she could also look in Resident #9's EMR to find the resident's advance directive. When told the EMR indicated Resident #9 was a DNR code status, the RN Supervisor suggested talking to the facility's social worker to inquire about the advance directive. An interview was conducted on 12/12/23 at 3:12 PM with Social Worker #1. When asked what Resident #9's advance directive was, Social Worker #1 confirmed the resident's EMR indicated she was a DNR code status. Upon further inquiry, the social worker reported she would need to look more into the resident's advance directive. A follow-up interview was conducted with Social Worker #1 and Social Worker #2 on 12/13/23 at 9:33 AM. During the interview, Social Worker #2 reported Resident #9 had an advanced directive to indicate she was a full code status. He explained the resident's advance directive was changed to a full code during her last care plan meeting on 11/20/23. Social Worker #2 stated	F 578	verified correct code status and made changes to the Resident #9 EMR that accurately reflected the residents correct code status. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice; 1. On 12/12/2023, the Director of Nursing/designee conducted an audit to ensure other resident code statuses accurately reflected code statuses in residents' EMR with no other discrepancies identified. 2. On 12/13/2023, nursing staff in-serviced on verifying code statuses upon admission and updating physical chart and EMR to ensure medical records accurately reflect code statuses. 3. On 12/13/2023, social workers in-serviced on ensuring nursing staff aware of code status changes resulting from care plan meetings, to ensure code status changes are reflected on telephone orders, physical chart, and EMR. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; 1. Starting on 01/02/2024, the DON or Designee will use admission/documentation audit form to ensure code statuses reflect the same code status in the physical chart and the electronic medical record for each new admission.	

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F 578	Continued From page 7 the inquiry made on 12/12/23 prompted the social workers to speak with Resident #9 to confirm what was said in her care plan meeting. The resident confirmed she was a full code, so her code status was changed to "full code" in her EMR on 12/12/23. When asked who was responsible to change a resident's code status in the EMR, Social Worker #2 did not indicate any one person assumed this responsibility. He stated multiple disciplines had access to change a code status in the EMR and could do so. When asked if the advance directive indicated by a resident's paper chart should accurately reflect his/her code status in the EMR, Social Worker #2 responded by saying, "Of course." A follow-up interview was conducted with the RN Supervisor on 12/13/23 at 10:06 AM. During the interview, the RN Supervisor was informed that the concern related to Resident #9's advance directive was reported to have been resolved by the social workers on 12/12/23. When the RN Supervisor was told Resident #9's advance directive status had been changed on 11/20/23 at a care plan meeting to full code while her EMR still indicated she was a DNR code, the nurse stated, "That's a big difference." An interview was conducted with the facility's Director of Nursing (DON) on 12/14/23 at 1:13 PM. During the interview, the DON was asked to review Resident #9's active physician orders in her EMR. The physician orders still showed there an active physician order for "DNR/DNI" (Do Not Resuscitate / Do Not Intubate) with a start date of 2/25/23. The DON stated she had been made aware of the discrepancy found between Resident #9's paper chart and EMR advance directives. She recalled being told the social	F 578	2. Starting on 01/02/2024, nursing will immediately write telephone order and update electronic medical record to reflect any code status changes during the care plan meeting 3. Starting on 01/02/2024, 11pm-7am RN supervisor/Designee will recheck physical chart and electronic medical record against the written telephone order during nightly chart checks 4. The DON or Designee will conduct random audits on a minimum of 5 resident charts per unit to ensure code statuses are accurately reflected in the residents' EMR weekly x 4 weeks and biweekly x 2 months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; 1. This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting and the dates are subject to the vote of this interdisciplinary committee. Date: January 24, 2024	

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F 578	Continued From page 8 workers changed the DNR to "CPR" (cardiopulmonary resuscitation) on the banner in Resident #9's EMS. However, the DON reported the social workers may not have known to discontinue the physician's active order for DNR. She stated she would take care of this. During a follow-up interview conducted on 12/14/23 at 4:46 PM, the DON reported she would expect a resident's EMR, paper chart, and physician's orders to accurately document the same advance directive.	F 578		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640		1/7/24

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F 640	Continued From page 9 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure Minimum Data Set (MDS) assessments were transmitted to the Centers for Medicare and Medicaid Services (CMS) database for 26 of 26 residents reviewed for resident assessment (Resident #77, #84, #21, #88, #41, #18, #24, #92, #47, #44, #56, #47, #83, #75, #95, #28, #64, #81, #65 #36, #39, #94, #74, #19, #35, and #52). Findings included: a. Resident #77 had been admitted on 7/20/23. Their discharge MDS assessment dated 8/5/23	F 640	This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. [F 640] Encoding/Transmitting Resident Assessment Address how corrective action will be	

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F 640	Continued From page 10 was signed as completed on 8/18/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database. Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted. b. Resident #84 had been admitted on 7/12/23. Their discharge MDS assessment dated 8/3/23 was signed as completed on 8/17/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database. Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted. c. Resident #21 had been admitted on 7/14/23. Their discharge MDS assessment dated 8/5/23 was signed as completed on 8/19/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database. Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted. d. Resident #88 had been admitted on 7/25/23. Their discharge MDS assessment dated 8/6/23 was signed as completed on 8/18/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database. Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted. e. Resident #41 had been admitted on 4/23/18. Their most recent Quarterly MDS assessment dated 10/20/23 was signed as completed on 11/3/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database. Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted.	F 640	accomplished for those residents found to have been affected by the deficient practice; On 12/13/23 the Administrator contacted the software vendor and created a ticket to address problems with assessment transmissions. On 12/14/23 the MDS Nurse corrected and resubmitted the records of Residents #□s 41, 77, 36, 24, 44, 81, 64, and 75 who were similarly rejected due to an error in sections O0400A1 through O0420. Validation report received for this batch reflects rejection of each correction due to no previously accepted record in the iQIES System. On 12/21/23 the MDS Nurse repopulated a new assessment for Resident #36 and submitted it to the iQIES System. Upon receipt of acceptance of Resident #36□s assessment in the iQIES System, MDS Nurse proceeded to repopulate and complete a new assessment for the remaining resident□s (84, 21, 88, 18, 92, 47, 83, 95, 28, 65, 39, 94, 74, 19, 35, 52) that were rejected. Additional residents identified on the MDS 3.0 Missing OBRA Assessment Report will be audited, corrected and resubmitted to iQIES. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; MDS Nurse/designee will audit Validation Reports to identify assessments which have been rejected and perform	

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F 640	Continued From page 11 f. Resident #18 had been admitted on 7/20/23. Their discharge MDS assessment dated 8/4/23 was signed as completed on 8/18/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database. Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted. g. Resident #24 had been admitted on 1/29/15. Their most recent Quarterly MDS assessment dated 10/6/23 was signed as completed on 10/20/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database. Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted. h. Resident #92 had been admitted on 7/7/23. Their discharge MDS assessment dated 7/27/23 was signed as completed on 8/10/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database. Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted. i. Resident #47 had been admitted on 7/11/23. Their discharge MDS assessment dated 7/28/23 was signed as completed on 8/11/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database. Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted. j. Resident #44 had been readmitted on 3/6/23. Their most recent Quarterly MDS assessment dated 10/3/23 was signed as completed on 10/17/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database. Review of the CMS database on 12/12/23 did not	F 640	corrections for resubmission into the iQIES System. MDS Nurse/designee will monitor MDS 3.0 Missing OBRA Assessment Report routinely to identify assessments not accepted into the iQIES System and perform corrections and resubmissions as needed. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur; MDS Nurse to perform weekly audits of MDS 3.0 NH Final Validation Reports to identify errors requiring correction are performed and resubmitted timely to the iQIES System. MDS 3.0 Missing OBRA Assessment Reports will be audited routinely by MDS Nurse/designee to identify assessments that have not been accepted into the iQIES System are corrected and resubmitted. Updates by the software vendor to address changes in MDS 3.0 items and notifications of errors noted ongoing. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; MDS Nurse will transmit MDS assessment data within 14 days after completion to the IQIES system. MDS 3.0 NH Final Validation Reports will be reviewed to identify assessment errors and make corrections to ensure timeliness and acceptance by CMS. MDS Nurse/designee will audit the MDS 3.0	

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F 640	Continued From page 12 indicate this assessment had been accepted. k. Resident #56 had been admitted on 7/10/23. Their discharge MDS assessment dated 7/22/23 was signed as completed on 8/4/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database. Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted. l. Resident #17 had been readmitted on 5/27/23. Their most recent Quarterly MDS assessment dated 10/16/23 was signed as completed on 10/30/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database. Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted. m. Resident #83 had been admitted on 7/13/23. Their discharge MDS assessment dated 8/4/23 was signed as completed on 8/18/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database. Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted. n. Resident #75 had been admitted on 7/5/23. Their most recent Quarterly MDS assessment dated 10/9/23 was signed as completed on 10/23/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database. Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted. o. Resident #95 had been admitted on 7/21/23. Their discharge MDS assessment dated 8/8/23 was signed as completed on 8/22/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database.	F 640	Missing OBRA Assessment Reports routinely to ensure compliance with resident assessment standard. This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting. The Committee will review audits to ensure compliance and determine if additional audits or training is necessary.	

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Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted.
p. Resident #28 had been admitted on 6/26/23. Their discharge MDS assessment dated 7/26/23 was signed as completed on 8/9/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database.
Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted.
q. Resident #64 had been admitted on 7/7/23. Their discharge MDS assessment dated 8/8/23 was signed as completed on 8/22/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database.
Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted.
r. Resident #81 had been admitted on 4/4/23. Their most recent Quarterly MDS assessment dated 10/6/23 was signed as completed on 10/20/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database.
Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted.
s. Resident #65 had been admitted on 7/19/23. Their discharge MDS assessment dated 8/8/23 was signed as completed on 8/22/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database.
Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted.
t. Resident #36 had been readmitted on 7/20/22. Their most recent Quarterly MDS assessment dated 10/10/23 was signed as completed on 10/24/23. The facility's electronic medical record indicated the assessment had been transmitted

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and accepted to the CMS database.
Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted.
u. Resident #39 had been admitted on 7/6/23. Their discharge MDS assessment dated 7/27/23 was signed as completed on 8/10/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database.
Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted.
v. Resident #94 had been admitted on 7/11/23. Their discharge MDS assessment dated 8/1/23 was signed as completed on 8/15/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database.
Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted.
w. Resident #74 had been admitted on 6/15/23. Their discharge MDS assessment dated 7/27/23 was signed as completed on 8/10/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database.
Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted.
x. Resident #19 had been admitted on 7/13/23. Their discharge MDS assessment dated 8/4/23 was signed as completed on 8/18/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database.
Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted.
y. Resident #35 had been admitted on 7/25/23. Their discharge MDS assessment dated 8/5/23 was signed as completed on 8/18/23. The facility's electronic medical record indicated the

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F 640	Continued From page 15 assessment had been transmitted and accepted to the CMS database. Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted. z. Resident #52 had been admitted on 7/10/23. Their discharge MDS assessment dated 7/28/23 was signed as completed on 8/11/23. The facility's electronic medical record indicated the assessment had been transmitted and accepted to the CMS database. Review of the CMS database on 12/12/23 did not indicate this assessment had been accepted. On 12/13/23 at 8:48 AM an interview with the MDS Nurse was conducted. The MDS Nurse stated these assessments had been completed but something had happened with the transmission. She explained the facility used a vendor to transmit the MDS assessments. The vendor sends back the validation report and indicates if any of the assessments were rejected. After reviewing the validation reports, she explained that the assessments either had been rejected or had not been transmitted and should not have had the status changed in the system to "accepted". On 12/13/23 at 10:15 AM an interview with the Administrator was conducted. She stated she had been unaware of the MDS transmission problems. She explained she would have to make some calls to the vendor who transmits the assessments and figure out what happened and why they were not accepted into the CMS database.	F 640		
F 880 SS=J	Infection Prevention & Control	F 880		1/7/24

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F 880	Continued From page 16 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 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	F 880		

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F 880	Continued From page 17 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 observations, staff interviews, and record review, the facility staff failed to disinfect a shared blood glucose meter (glucometer) between residents with an approved disinfectant wipe for 2 of 3 residents whose blood glucose levels were checked (Resident #36 and Resident #81). This occurred while there was a resident with known bloodborne pathogens in the facility. Shared glucometers can be contaminated with blood and must be cleaned and disinfected after	F 880	This plan of correction constitutes Hillcrest Raleigh's written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	

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F 880	Continued From page 18 each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-approved disinfectant in accordance with the manufacturer's instructions for disinfection of the glucometer potentially exposes residents to the spread of blood borne infections. Immediate Jeopardy began on 12/13/23 when Nurse #1 was observed attempting to perform blood glucose testing for two residents on her assigned hall using a shared glucometer. Nurse #1 used a hand sanitizing wipe (intended to remove light soil and dirt from hands) to clean the shared glucometer between the two residents instead of using an EPA-approved disinfectant wipe to clean/disinfect the shared glucometer. Immediate Jeopardy was removed on 12/15/23 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 D (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's policy entitled "Obtaining a Fingerstick Glucose [Sugar] Level" (not dated) included: Purpose: The purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level. --Preparation: 1. Assemble equipment and supplies needed. Equipment and Supplies: 2. Glucose meter (glucometer) with single use	F 880	{F880} Infection Prevention & Control Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. On 12/13/2023 Nurse #1 was stopped by state surveyor before performing second accucheck on Resident #81. 2. On 12/13/2023 Nurse #1 was re-educated by DON to policy and procedure for cleaning blood glucometer machines and materials to be used to clean the glucometer by DON (Previous education given and acknowledge by Nurse #1) 3. On 12/13/2023 Name brand hand sanitizer was removed from Nurse #1's cart by DON/Designee. 4. On 12/13/2023 Registered EPA cleaning disinfectant was placed on Nurse #1's cart. 5. It was determined by DON that Nurse # 1 had performed accuchecks on 5 residents on 12/13/2023, Residents #36, #70, #81, #90, and # 264. 6. On 12/13/2023 Medical records were checked by DON to confirm no residents who had received an accucheck from Nurse #1 on 12/13/2023 had a diagnosis of blood borne pathogens. 7. On 12/13/2023 MD was notified by DON that a non-EPA registered cleaning disinfectant had been used to clean the blood glucose meter (glucometer) used on Resident #36. 8. On 12/13/2023 new orders were given by MD to monitor resident #36 for any	

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F 880	Continued From page 19 safety lancet (disposable); 3. Single use alcohol swab; and 4. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed). --Steps in the Procedure: 5. Place the equipment on the bedside stand or overbed table. Arrange the supplies so that they can be easily reached. 6. Wash hands; Wear clean gloves. 7. If alcohol is used to clean the fingertip, allow it to dry completely because the alcohol may alter the reading. 8. Obtain a blood sample by using a new disposable safety lancet with each fingerstick. Place a drop of blood on the reagent strip. 9. If bleeding persists, apply a bandage. 10. Discard lancet into sharps container. 11. Remove gloves, discard appropriately. 12. Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. 13. Wash hands. The manufacturer's User Guide for the glucometer used at the facility included "Important Safety Instructions." These instructions noted, in part, "The meter should be disinfected after use on each patient. This 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 Disinfecting Procedures for the Meter" read in part, "The [Brand Name] meter should be cleaned and disinfected between each patient." A list of products approved for cleaning and disinfecting the glucometer was provided by the manufacturer. The glucometer's manufacturer	F 880	adverse reactions that could be related to use of a non-EPA registered disinfectant on a glucometer. 9. On 12/13/2022 resident #36 and their Responsible Party were notified by DON and made aware of non-EPA registered disinfectant used to clean glucometer and new orders from MD to monitor for adverse reactions. 10. On 12/13/2023 MD was notified by DON that a non-EPA registered cleaning disinfectant may have been used to clean the glucometer used on Resident #70, #81, #90 and #264 the morning of 12/13/23. 11. On 12/13/2023 new orders were given by MD to monitor Residents #70, #81, #90 and #264 for any adverse reactions that could be related to use of non-EPA registered disinfectant to clean a glucometer. 12. On 12/14/2023 DON notified residents #70, # 81, #90 and #264 and their Responsible Parties that a non-EPA registered disinfectant may have been used to clean glucometer and new orders had been received from MD to monitor for adverse reactions. 13. On 12/14/2023 local Department of Health was called by Executive Director and made aware of use and possible use of non-EPA registered disinfectant being used to clean glucometer, no instructions provided by Department of Health as to follow-up steps to be taken. Address how the facility will identify other residents having the potential to be affected by the same deficient	

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F 880	Continued From page 20 also noted, "Other EPA registered wipes may be used for disinfecting the [Brand Name] system, however, these wipes have not been validated and could affect the performance of your meter ..." Two types of disinfectant wipes were available for use at the facility to disinfect a shared glucometer: Disinfectant Wipe #1 was listed as an approved product by the manufacturer of the glucometer for cleaning/disinfecting the facility's (Brand Name) glucometer; Disinfectant Wipe #2 was not specifically listed as approved by the manufacturer of the glucometer for cleaning and disinfecting the facility's glucometers. However, Disinfectant Wipe #2 was also an EPA-registered product effective against human immunodeficiency virus (HIV-1), hepatitis B virus (HBV) and hepatitis C virus (HCV). The directions for use printed on the manufacturer's label of Disinfectant Wipe #2 read in part: "This product kills the following viruses in 2 minutes on pre-cleaned hard, non-porous surfaces at room temperature when used as directed." Special instructions for cleaning and decontamination against HIV-1, HBV and HCV indicated, "Contact Time: Allow hard, non-porous surfaces to remain wet for 2 minutes to kill HIV-1, HBV, and HCV." The facility provided a listing of the education topics provided to Nurse #1. A form signed by Nurse #1 and dated 10/4/23 acknowledged annual training was received on 26 topics. The topics included, in part: Fasting Blood Sugar Checks and Insulin; Infection Control; and Blood-Borne Pathogens. A portion of the educational material received by Nurse #1 read: "Each Med [Medication] Cart should have 2 Blood Sugar Glucometers. Nurses should alternate	F 880	practice: 1. On 12/13/2023 census pulled and facility identified 21 residents currently receiving accuchecks. 2. On 12/13/2023 Evercare G3 Primary Care representative called by DON to verify that any Registered EPA cleaning disinfectant product could be used to clean the glucometers. 3. On 12/13/2023 all nursing carts were checked by DON/Designee for appropriate EPA registered cleaning disinfectant product as identified by glucometer supplier. 4. On 12/13/2023 all other nursing carts were found by DON/Designee to have appropriate EPA registered cleaning disinfectant product. (McKesson Disposable Germicidal Surface wipes. EPA REG# 70144-2-80366) Will order suggested EPA registered disinfectant by Evercare 5. Purple Top Micro Kill ordered by DON and received at facility on 12/13/2023. 6. On 12/13/2023 all nursing carts checked by DON/Designee for 2 glucometers to be alternated between 7. On 12/13/2023 residents and all nursing carts were determined to have 2 glucometers. 8. On 12/13/2023 brand name hand sanitizing wipes were removed from all carts by DON/Designee 9. On 12/13/2023 all nurses performing accuchecks were interviewed by DON to determine if they had used appropriate EPA registered cleaning disinfectant when	

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F 880	Continued From page 21 using machines when doing Accuchecks [blood glucose checks]. Machines should be cleaned with Germicidal wipes (white top). Leave Open to air to dry, before next use." An observation was conducted on 12/13/23 at 11:55 AM as Nurse #1 collected supplies (a vial of test strips, a lancet, and an alcohol wipe) and obtained a glucometer from the medication cart in preparation to conduct a blood glucose check for Resident #36. The glucometer was not labeled with a resident's name. Nurse #1 was accompanied as she carried the glucometer and supplies down to Resident #36's room. After entering the room, the nurse put the glucometer and supplies down on a paper towel placed on the resident's bedside tray table. While wearing gloves, the nurse wiped the resident's finger with an alcohol pad, used a lancet to obtain a drop of blood from his finger and applied the blood to the test strip inserted into the glucometer. Once the blood glucose results were obtained, Nurse #1 discarded the trash and lancet, then returned to the medication cart with the glucometer. The nurse was observed as she pulled a (Brand Name) Hand Sanitizing Wipe from its container placed on top of the medication cart. She used this hand sanitizing wipe to wipe off the glucometer used to test Resident #36's blood glucose level. The nurse then collected supplies from the medication cart to check another resident's blood glucose and picked up the glucometer she had just wiped off with the hand sanitizing wipe. Nurse #1 was accompanied as she walked down the hall to do the blood glucose check for Resident #81. On 12/13/23 at 12:00 PM, the nurse reached the door of Resident #81's room. At that time, the nurse was asked to stop before entering the resident's room. The nurse	F 880	cleaning glucometers. All nurses verified that they were aware of the need to use EPA registered cleaning disinfectant to clean glucometers and had been using EPA registered cleaning disinfectant to clean glucometers. 10. Medical records were checked by DON and it was confirmed that no resident receiving accuchecks had been diagnosed with blood borne pathogens. 11. On 12/13/2023 all nurses and med aides were educated by DON on policy and procedure for obtaining a fingerstick glucose level, the use of an EPA registered disinfectant product and the specific use of “Purple Top Micro Kill Disinfected” to disinfect glucometers. 12. On 12/13/2023 nurses and med aides required to acknowledge education given via Onshift, email, or text before performing Blood Glucose accucheck. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; 1. Facility will begin implementing single patient use blood glucose meters on 1/4/2024. All current resident issued new glucometer on 1/4/2024 2. On 1/4/2024 facility will begin implementing all nurses and med aides will be trained by DON or her designee prior to administration of single patient blood glucose meters. Training will include: a. Operating Procedure b. Policy/procedure to include infection	

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F 880	Continued From page 22 was questioned as to whether the wipes used to clean the shared glucometer was an appropriate disinfectant wipe. She was asked to return to the medication cart. As Nurse #1 walked back to her medication cart located next to the nurses' station, the nurse reported she typically did not use the hand sanitizing wipes to clean a glucometer. Nurse #1 held up an alcohol wipe and stated she usually used an "alcohol wipe" to clean the glucometer between residents. The alcohol wipe held up by the nurse was an alcohol pad used to clean a resident's finger prior to drawing blood for the blood glucose check. At that time, the nurse was informed that an alcohol wipe was not an approved disinfectant for a glucometer. Upon reaching the medication cart on 12/13/23 at 12:01 PM, Nurse #1 asked the Registered Nurse (RN) Supervisor what disinfectant wipes she should use to clean/disinfect the shared glucometer between residents. The RN Supervisor came over to the medication cart and was observed as she looked in the drawers of the medication cart to see if disinfectant wipes were on the medication cart. No disinfectant wipes were found on the medication cart. The RN Supervisor left the nurses' station to obtain approved disinfectant wipes for the glucometer. While she was gone, a container of Disinfectant Wipes #2 was located at the nurses' station. After reviewing the manufacturer's labeling and directions for use for Disinfectant Wipes #2, Nurse #1 used these wipes, per manufacturer's directions, to disinfect the shared glucometer. On 12/13/23 at 12:05 PM, an interview was conducted with Nurse #1. Upon inquiry, Nurse #1 reported she used this shared glucometer to	F 880	control and cleaning of glucometer c. Storage d. Maintenance e. Quality control tests 3. 1/4/2024 facility policy for Obtaining a Fingerstick Glucose (Sugar) Level revised to address use of single patient use blood glucose meters. 4. 1/4/2024 all multi-use blood glucose meters pulled from nurses carts by DON or her designee. 5. On 1/4/2024 new individual blood glucose meters issued to all current residents needing glucose meters during their stay at the facility. 6. On 1/4/2024 future resident's needing glucose sugar level checks will be issued an individual glucose meter. 7. On 1/4/2024 each resident's individual blood glucose monitoring device will be stored in an individual zip lock bag, labeled with their name in the resident's room. 8. Upon discharge, the resident who needs to continue blood glucose monitoring at home, but does not have a meter at home will be given the device. 9. On 1/4/2024 DON or her designee will begin to supervise the quality control process to ensure that individual blood glucose meters are being used and cleaned in accordance with facility policy and manufacturer's instructions and provide ongoing employee education as necessary. 10. Facility registered with QIO (Alliant) to assist in implementation of Directed Plan of Correction on 1/4/24.	

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F 880	Continued From page 23 check the blood glucose levels of residents on her assignment earlier that morning. These residents were identified by their electronic medical records (EMRs) as Resident #36, #81, #264, #70 and #90. When asked if she usually cleaned the glucometer before or after use with the alcohol wipes, the nurse stated "both." Upon request as to where the shared glucometer was stored, the nurse opened the top drawer of the medication cart revealing a second glucometer placed in a plastic basket with a bottle of test strips. Nurse #1 reported both shared glucometers were stored in the basket on the medication cart when they were not in use. The nurse stated while the second glucometer also worked, she had only used the one shared glucometer earlier that morning to complete the blood glucose checks. A follow-up interview was conducted on 12/14/23 at 8:00 AM with Nurse #1. During the interview, the nurse was asked to confirm what she used to clean/disinfect the shared glucometer between residents when she checked their blood glucose levels on the morning of 12/13/23. Nurse #1 stated she used the wipes with the white top (referring to Disinfectant Wipes #2). At that time, Nurse #1 was reminded that while walking back to the medication cart after being stopped from checking Resident #81's blood glucose on 12/13/23, the nurse held up an alcohol wipe and stated she usually used an "alcohol wipe" to clean the shared glucometer between residents. The nurse then stated she, "didn't mean those alcohol wipes." Nurse #1 added that she meant she used the germicidal wipes with the white top. When reminded there were no approved disinfectant wipes found on her medication cart, the nurse stated she used the disinfectant wipes	F 880	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 1. Random audits of each nursing medication carts (6 carts) will be performed to ensure no single-resident use glucose meters are stored and used for multi-use. Audits will be conducted by DON/designee for a period of weekly X 4 weeks, and bi-weekly X 2 months. 2. Random audits of all residents with glucometers will be conducted weekly X 4 weeks and bi-weekly X2 months to ensure single-resident glucometers in place. 3. The Quality Assurance Committee will review audits and Conduct interview with DON to ensure compliance and determine if additional audits or training are necessary.	

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at the nursing station on the morning of 12/13/23.

The RN Supervisor returned to the medication cart at 12:10 PM with a second container of Disinfectant Wipes #2. At that time, the RN Supervisor confirmed Disinfectant Wipes #2 were the correct wipes for disinfecting the facility's glucometers.

On 12/13/23 at 12:20 PM, the facility's Director of Nursing (DON) was informed of the concern related to the facility's failure to use an EPA-approved disinfectant to clean/disinfect a shared glucometer. During the interview, the DON was informed [Brand Name] Hand Sanitizing Wipes were observed to be used to clean a shared glucometer between residents, but the nurse was stopped during the observation (before the shared glucometer could be used for a second resident). The DON was also informed Nurse #1 reported she typically used an alcohol wipe (not an EPA-approved disinfection product) to clean/disinfect a shared glucometer. At that time, the DON stated the nursing staff had been educated on multiple occasions on the proper disinfection of glucometers and the appropriate disinfection product that needed to be used. She reported the facility had two appropriate products for glucometer disinfection (referring to Disinfectant Wipe #1 and Disinfectant Wipe #2).

An interview was conducted on 12/13/23 at 2:10 PM with the facility's Administrator. During the interview, the Administrator reported she had been informed of the concern related to the failure of a nurse to use an EPA-approved disinfectant between residents for a shared glucometer. She stated the appropriate disinfectant wipes had been passed out after the

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concern related to glucometer disinfection was identified so the EPA-approved disinfectant wipes would be available on each medication cart for use. At that time, the Administrator was asked for a listing of residents in the facility who were diagnosed with a known blood borne pathogen.

A review of the EMR and medical diagnoses for current residents at the facility was conducted. One resident was identified as having diagnoses which included two blood borne pathogens (HIV and acute hepatitis B).

The facility's Administrator and DON were informed of the immediate jeopardy on 12/13/23 at 2:20 PM.

The facility provided the following plan for IJ removal.

Credible Allegation of Compliance Demonstrating Removal of Immediate Jeopardy

---Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

-It was determined that the brand named hand-sanitizing wipes were on one medication cart on December 13, 2023.
-Prior to December 13, 2023, the only glucometer cleaning wipes on the medication cart were manufacturer's approved equipment germicidal wipes.
-It was determined based on investigation by the DON and her designee that Nurse #1 had only used the brand named hand-sanitizing wipes to clean the glucometer before using the glucometer for Resident #36.

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F 880	Continued From page 26 -Nurse #1 only was assigned to conduct blood glucose checks on 5 residents (#36, #81, #264, #70 and # 90) on December 13, 2023. -However, Nurse #1 who conducted the observed blood glucose checks reported to the surveyor that she normally used an alcohol wipe to clean the shared glucometer. The alcohol pad that is used to clean a resident's finger before blood is drawn, is not a manufacturer approved equipment germicidal wipe. -Any of the 5 residents for whom Nurse #1 was assigned to conduct a blood glucose check could have been impacted by the alleged non-compliance. -The medical records for the 5 residents were reviewed by the DON and her designee on December 13, 2023. (On December 13, 2023, there were 21 residents in the entire facility who required blood glucose checks.) No other nurses had the brand named hand-sanitizing wipes on their cart, all other nurses were observed with the correct germicidal wipes on their cart. -It was determined that none of the 5 residents who could have been checked by Nurse #1 had a diagnosis of a blood-borne pathogen. The resident referenced in the immediate jeopardy template as having a blood-borne pathogen did not receive blood glucose checks. ---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. -All 6 medication carts were checked on December 13, 2023, by DON or designee. No other medication cart was found with the brand named hand-sanitizing wipes. -DON or designee determined on December 13,	F 880		

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2023, that all the medication carts had manufacturer recommended germicidal wipes for cleaning the glucometer. The medication cart used by Nurse #1 did not have the recommended germicidal wipes on her cart. The DON did confirm with Nurse #1 that the germicidal wipes were within her reach at all times.
-On December 13, 2023, the brand named hand-sanitizing wipes were removed from use in the facility by DON or designee.
-On December 13, 2023 in-service began by DON for all nurses and med aides, including Agency staff, pertaining to use of the glucometer and cleaning the glucometer with a germicidal EPA registered disinfectant wipe.
-All nurses and medication aides will be in-serviced prior to the start of their shift
-No nurse or medication aide will be permitted to perform blood glucose checks or use a glucometer until they have been in-serviced.
-Starting December 13, 2023 DON or her designee will monitor staff to ensure compliance until shift supervisors are trained regarding in-services and monitoring. Once trained, shift supervisors will monitor and train staff (to include agency staff) prior to their shift.
-On December 13, 2023, DON notified Wake County Health department, regarding the use of brand named hand-sanitizing wipes to clean a glucometer.
-On December 14, 2023, DON or designee notified Wake County Health department, regarding the potential use of an alcohol based wipe rather than a manufacturer's approved equipment germicidal wipes to clean a glucometer
-On December 13, 2023, DON notified Resident #36 and their responsible parties regarding the use of brand named hand-sanitizing wipes to

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clean a glucometer.
-On December 14, 2023, DON or her designee notified Residents #81, #264, #70 and # 90 and all 5 resident's responsible parties of the potential use of an alcohol based wipe rather than a manufacturer's approved equipment germicidal wipes to clean a glucometer.
-On December 13, 2023, DON notified the physician for Resident #36 regarding the use of brand named hand-sanitizing wipes to clean a glucometer.
-On December 14, 2023, DON or her designee notified the physician for Residents #81, #264, #70 and # 90 of the potential use of an alcohol based wipe rather than a manufacturer's approved equipment germicidal wipes to clean a glucometer
-Physician ordered monitoring of Resident #36 for signs and symptoms of adverse reactions.

The immediate jeopardy was removed on 12/15/23.

The facility's credible allegation of immediate jeopardy removal was validated on 12/15/23. Documentation of the County Health Department, physician, and residents' Responsible Party notification was provided and reviewed. The validation was also evidenced by nurse observations and interviews conducted on each hallway with regards to the required infection control practices for the use of shared glucometers. All nurses who were interviewed reported they had received the required in-service training. This training included the importance of using an approved disinfectant wipe and disinfecting a shared glucometer with the proper procedures in accordance with the manufacturer's instructions for the disinfectant.

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F 880	Continued From page 29 Observations were conducted on each hallway as blood glucose checks were conducted and glucometers were disinfected. Multiple observations also confirmed EPA-approved disinfectant wipes were stored on each medication cart and containers of the [Brand Name] Hand Sanitizing Wipes were no longer observed on the halls or medication carts. The credible allegation was validated, and the immediate jeopardy was removed on 12/15/23.	F 880		