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	345223	A. BUILDING ______ B. WING ______	C 04/10/2024

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/01/24 through 04/10/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 9E3H11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 04/01/24 to conduct a recertification and complaint investigation survey. The survey team was onsite 04/01/24 to 04/05/24. The survey team returned to the facility on 4/10/24 to validate the corrective action plan and the immediate jeopary removal plans. Therefore, the exit date was changed to 04/10/24. Event ID# 9E3H11. The following intakes were investigated: NC00213550, NC00210243, NC00204302, NC00200988, and NC00200151. 2 of the 18 complaint allegations resulted in deficiency. Intake NC00200988 resulted in Immediate Jeopardy. Immediate Jeopardy was identified at: CFR 483.35 at tag F726 at a scope and severity J. CFR 483.80 at tag F880 at a scope and severity J. Immediate Jeopardy began on 04/03/24 and was removed on 04/05/24. Immediate Jeopardy at past non-compliance was identified at: CFR 483.25 at tag F689 at a scope and severity J.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 04/29/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Tag F689 constituted Substandard Quality of Care. Immediate Jeopardy for example #1 began on 04/11/23 and was removed on 04/13/23. Immediate Jeopardy for example #2 began on 02/02/24 and was removed on 02/05/24. An extended survey was conducted.	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, record review and resident and staff interviews, the facility failed to assess the ability of a resident to self-administer medications for 1 of 1 sampled residents observed with medications left at bedside (Resident #127). Findings included: Resident #127 was admitted to the facility on 03/20/24 with diagnoses that included heart failure, diabetes and chronic pain. A physician's order dated 03/20/24 for Resident #127 read, antacid oral tablet 500 milligrams (mg) - give two tablets by mouth at bedtime (8:00 PM) for supplement. The admission Minimum Data Set (MDS) dated 03/26/24 revealed Resident #127 had intact	F 554	•Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. F554 – Self-Administration of Drugs Step One: A medication cup containing two Tums chewable tablets was observed on the bedside table, medications were immediately removed from resident room and discarded. An evaluation for self-administration of medications was completed immediately for this resident and resident prefers not to self-administer medications. Step Two: All current residents have the potential to be affected by this deficient practice. The Director of Nursing or	4/10/24

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F 554

Continued From page 2
cognition.
Review of Resident #127's medical record revealed no documentation he was assessed for self-administration of medications.

Observations on 04/01/24 at 8:50 AM and 10:41 AM revealed Resident #127 lying in bed, sleeping soundly, with the overbed table pulled directly in front of him. Placed on top of the overbed table was a medicine cup containing one round white pill and one round pink pill.

During an observation and joint interview with Resident #127 on 04/01/24 at 11:58 AM, Med Aide #1 stated the pills in the medicine cup were antacids and as far as she knew Resident #1 had not been assessed to self-administer his medications nor did he have a physician's order. Med Aide #1 was not sure who had administered Resident #127's antacid medication and stated the pills should not have been left unattended on his overbed table.

During a joint interview with Med Aide #1 on 04/01/24 at 11:58 AM, Resident #127 stated he was not sure who brought him the medication that was left on his overbed table. When asked by Med Aide #1 why he didn't take the medication, Resident #127 replied, "probably because I didn't know they were there."

Nurse #4 was not working during the survey and unable to be interviewed.

During an interview on 04/01/24 at 12:39 PM, Unit Manager #1 stated Resident #127's antacid medication should not have been left at bedside since Resident #127 had not been assessed to self-administer medications and he did not have a

F 554

designee interviewed all residents with a BIMS of 12 or above regarding self-administration of medications. Only one resident was identified that wished to self-administer medications and had a Self-Administration of Medication assessment completed, a physician’s order was obtained and resident’s care plan was updated. Audits were completed on 4/8/24.

Step Three: To prevent this from reoccurring, the Director of Nursing or designee educated all licensed nursing staff and all current agency nursing staff and medication aides on the Medication Administration Policy. The Director of Nursing or designee educated all licensed nursing staff including current agency nursing staff on completion of the Self-Administration of Medication assessment and when this assessment is to be completed; completion at the time that physician order is given, then quarterly. The Director of Nursing or designee educated all licensed nursing staff including agency nursing staff and medication aides that medications are not to be left at bedside or given to the resident for self-administration and/or to keep at bedside unless there is an active physician order, a completed and in-date assessment and is care planned appropriately. This education was completed on 4/10/24. The Director of Nursing or designee will educate all new agency staff and newly hired nursing staff and medication aides on the Medication Administration Policy and

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F 554	Continued From page 3 physician's order to self-administer medications. During an interview on 04/04/24 at 2:31 PM, the Director of Nursing (DON) explained self-administration of medication assessments were only done at the resident's request and could be completed by any nurse. The DON confirmed Resident #127 had not been assessed to self-administer medications and his antacid medication should not have been left unattended on the overbed table in his room. The DON stated nurses were expected to wait at bedside for residents to take their oral medications prior to leaving the room.	F 554	Self-Administration of Medication Policy prior to the start of their shift. Step Four: To monitor and maintain ongoing compliance, the Director of Nursing or designee will audit resident rooms at random, at least 5 rooms around medication pass times, weekly for 12 weeks. The Director of Nursing or designee will interview all new admissions with a BIMS of 12 or above and if they wish to self-administer medications, a Self-Administration of Medication assessment will be completed, a physician's order obtained and resident's care plan will be updated to reflect self-administration weekly for 12 weeks. Findings of the audits will be reviewed with the Interdisciplinary Team at QAPI meetings, revising plan and interventions as indicated for 3 months. The Director of Nursing/designee is responsible for this plan of correction. Date of Compliance: 4/17/24	
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.	F 578		4/10/24

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F 578	Continued From page 4 §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. (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 observations and staff interviews the facility failed to ensure code status information was accurate throughout the paper and electronic medical record for 1 of 2 residents reviewed for advanced directives (Resident #18). Findings included:	F 578	•Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. F 578 Request/Refuse/Discontinue Treatment	

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Resident #18 was admitted to the facility 01/03/24.

Review of Resident #18's care plan initiated 01/05/24 revealed she had an advance directive as noted by having a Do Not Resuscitate (DNR) status.

The quarterly Minimum Data Set (MDS) assessment dated 01/06/24 revealed Resident #18 was severely cognitively impaired.

Review of Resident #18's electronic medical record (EMR) was conducted 04/04/24. The banner (an area at the top of the computer screen which contains important information about the resident) at the top of Resident #18's EMR revealed she had an advance directive which read "DNR."

A review of the "Code Book" (a book containing hard copies of advance directives) kept at the nurses' station revealed a signed MOST (Medical Order for Scope of Treatment) form dated 10/17/23 that indicated Resident #18 was a "Full Code." The "Code Book" also contained a signed "DNR" form dated 01/03/24 for Resident #18.

An interview with Unit Manager #1 on 04/04/24 at 1:52 PM revealed a resident's code status could be verified by checking the computer or the "Code Book" kept at the nurse's station. When Unit Manager #1 was shown the "Code Book" with conflicting documentation regarding Resident #18's code status, she stated she guessed the most recently signed advance directive would be followed, but code status would have to be clarified with the resident's family and physician.

F 578

Step One: On 4/5/2024 The Social Services Director/designee immediately removed the outdated Medical Orders for Scope of Treatment (MOST) form from the code book and confirmed the code status with Resident #18's Power of Attorney. Social Services Director reviewed and updated the affected resident's Advanced Directive care plan and MOST form and ensured that the correct form remained in the code book.

Step Two: All residents have the potential to be affected by this deficient practice. On 4/8/2024, the Social Services Director/designee completed a 100% audit of all residents Advanced Directives and MOST forms to ensure that each residents' current advanced directives were correct and present in the code book. Advanced Directives and Most forms are reviewed and updated by Social Services Director at each resident's quarterly care plan meeting, upon admission to the facility, readmission to the facility, and as appropriate per significant change or at the request of the resident/POA.

Step Three: To prevent this from recurring, the Social Services Director/designee will educate all licensed nursing staff on the Advanced Directive policy, Advanced Directives care plans and on the Advanced Directive forms (MOST/Golden Rod). Education on the Advanced Directive binders containing the Advanced Directive forms, which are located at each nurse's station, was also

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An interview with the Director of Nursing on 04/04/24 at 3:09 PM revealed a "Code Book" was kept at each nurse's station to allow for easy access to determine code status but nursing staff could also check the computer for code status. She stated if code status was changed or updated the old advance directive form should be removed from the "Code Book," the correct advance directive form should be placed in the "Code Book," and the EMR should reflect the correct code status. The DON stated the advance directive form in the "Code Book" should match the banner in the resident's EMR. She stated she did not have a specific process for ensuring residents' paper advance directives matched the code status in the residents' EMR, but maybe the Social Worker (SW) had a process for checking advance directives.

An interview with the Social Worker on 04/04/24 at 3:27 PM revealed all invitations to care plan meetings provided to residents or family members listed the resident's code status and had a disclaimer that read along the lines of, "If this (code status) information is not correct or if you have changed your mind, please notify us." She stated she also tried to check the "Code Book" monthly for accuracy, but if she was not able to review the book monthly, it was reviewed annually at the end of the year. The SW confirmed code status documentation should match in the residents' EMR and "Code Book."

F 578

provided to all licensed nursing staff. All education will be completed by 4/9/2024.
For any new resident or returning resident entering the facility, the licensed nurse will enter the Advanced Directives order in the electronic medical record and then place any Advanced Directive forms (MOST/Golden Rod) in the Social Service Director’s mail box, the Social Services Director/designee will review the order, care plan and forms for accuracy and then file in the appropriate location within the Advanced Directive binder.

Step Four: To monitor and maintain compliance, the Social Services Director/designee will audit 5 resident’s Advance Directive order, care plan and Advanced Directive forms (MOST/Golden Rod) for accuracy weekly for 12 weeks. Social Services Director/Designee will review Advanced Directive Binders for accuracy weekly for 12 weeks. Social Services Director will audit Advanced Directives and MOST forms at each resident care plan, admission and readmission or as requested by the resident/POA to ensure that residents most current wishes are updated in the Advanced Directives care plan, MOST form, order, and binder, this will be done weekly for 12 weeks.
Results will be taken to QAPI for review and revision as needed for the next 3 months.
The Social Services Director/designee is responsible for this plan of correction.

Date of Compliance: 4/9/2024

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F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to prevent a resident with a court-appointed guardian who required supervision with leave of absences, a previous elopement attempt, and wore an elopement alarm monitoring device (Resident #127) from exiting the facility unsupervised and without staff knowledge. The facility also failed to prevent a resident with impaired cognition who had a history of exit seeking behavior and wore an elopement alarm monitoring device (Resident #67) from exiting the facility unsupervised and without staff knowledge. The deficient practice was for 2 of 5 sampled residents reviewed for accidents. On 04/11/23, Resident #127 was last seen in the facility at approximately 10:30 AM walking toward the dining room. At 11:15 AM Nurse Aide (NA) #1 went to look for Resident #127 and when Resident #127 was unable to be located inside the building, a Code Green (missing person) was called at 12:00 PM and a facility-wide search was conducted by staff which included the outside perimeter of the building and surrounding areas. At approximately 1:10 PM, Resident #127 was found at a location off facility property and brought back to the facility by law enforcement. On 02/02/24, Resident #67 was last observed in	F 689	Past noncompliance: no plan of correction required.	

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the facility at approximately 7:10 AM walking toward the front lobby. At approximately 7:15 AM, as NA #2 and NA #3 were leaving work they observed Resident #67 outside in the facility parking lot squatted down between two parked cars. Resident #67 was escorted back into the facility by NA #2 and NA #3. There was a high likelihood Resident #127 and Resident #67 could have suffered serious injury, harm or death when they were outside the facility unsupervised.

Findings included:

1. Resident #127 was readmitted to the facility on 02/25/21 with diagnoses that included diabetes, end-stage renal disease, history of falls, depression, and generalized anxiety disorder.

A State of NC Order on Motion for Appointment of Interim Guardian document dated 02/25/21 read in part, "A hearing on the movant's Motion for the Appointment of an Interim Guardian was held on this day. From the evidence presented at the hearing, the Court makes the following specific findings of fact: 1) Respondent does not have capacity presently to manage medical care and appointments and has been hospitalized due to not attending medical appointments required to keep him alive, 2) Respondent is currently hospitalized with multiple serious medical conditions, and 3) Respondent will likely die if released from the hospital without assistance of a guardian. Based on these specific findings of fact, the Court concludes that there is reasonable cause to believe that the respondent is incompetent and that the respondent is in a condition that constitutes or reasonably appears to constitute an imminent or foreseeable risk of harm to the respondent's well-being, and there is

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immediate need for a guardian to provide consent or take other steps to protect the respondent."

A State of North Carolina Letter of Appointment Guardian of the Person document dated 04/06/21 revealed Resident #127 was assigned a court-appointed Guardian with the reason marked as "incompetent person."

A care plan initiated on 06/28/19 revealed Resident #127 had a communication problem related to language barrier. His primary language is Spanish. Interventions included to notify nurse of any changes in ability to communicate and possible factors which cause/make worse/improve any communication problems, speak on an adult level clearly and slower than normal, and validate Resident #127's message by repeating aloud.

A care plan initiated on 11/18/22 revealed Resident #127 required supervision on Leave of Absence (LOA) from the facility due to poor safety awareness. Interventions included to educate Resident #127 and his Guardian on LOA policy and procedure and refer to Social Service/designee for review and reeducation if Resident #127 does not follow LOA procedures.

A care plan initiated on 12/09/22 revealed Resident #127 was at risk for injury related to an attempted elopement that was stopped by staff before he exited the building, delirium related to believing he still had an apartment locally and expressing intent to leave the facility to go to his apartment or to Florida. Interventions included to monitor and report changes in behavior such as restlessness and pacing and provide diversional activities of interest such as offering a snack or

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playing music he enjoys.

A care plan initiated on 12/15/22 revealed Resident #127 had an acute (sudden in onset) confusional state characterized by changes in consciousness, disorientation, environmental awareness or behavior. Resident #127 continues to have delusions and was recently started on antipsychotic medication. Interventions included to discuss feelings about placement, keep environmental noise/stimulation to a minimum, observe and report any changes in mental status, provide medications to alleviate agitation as ordered by the physician, and monitor/document side effects/effectiveness.

A care plan initiated on 04/12/23 revealed Resident #127 had an impaired ability to make self-understood related to primary language other than English. Resident #127 spoke Spanish. Interventions included to arrange for an interpreter as needed, maintain eye contact when communicating, pronounce words correctly, and use an alternative method of communication such as flip chart or translator.

A physician order for Resident #127 dated 12/20/22 read in part, check elopement alarm monitoring device via testing machine every day. The order was discontinued on 03/21/23.

A physician order for Resident #127 dated 12/20/22 read in part, visually check elopement alarm monitoring device placement every shift. The order was discontinued on 03/21/23.

The quarterly Minimum Data Set (MDS) assessment dated 03/03/23 assessed Resident #127 with intact cognition. Resident #127 was

F 689 Continued From page 11 F 689

independent with walking and locomotion and displayed no behaviors during the MDS assessment period.

Review of Resident #127's medical record revealed an Elopement Assessment was completed on 12/09/22 that revealed Resident #127 was considered high risk for elopement. The assessment consisted of the following 4 sections:
Mobility Status: Is the resident physically capable of leaving the facility? The answer was marked as 'yes.'
Mental Status: Is resident alert and oriented times three? The answer was marked as 'no.'
Wandering Behavior: Does the resident wander within the facility or have a history of wandering? Does the resident verbalize or exhibit exit seeking behavior? Both questions were answered 'yes.'
History: Has there been previous history of attempted or actual elopement or unsafe wandering? The answer was marked 'yes.'
There were no further elopement assessments completed after 12/09/22 until 04/11/23.

A staff progress note dated 04/11/23 at 3:30 PM written by the Social Worker (SW) read in part, "Guardian was notified of incident with Resident #127 as follows: 12:15 PM - notified facility was looking for resident; 1:38 PM - notified Resident #127 was located; 1:43 PM - notified Resident #127 was refusing to come into the facility; 2:20 PM - notified Resident #127 was sent to the hospital for involuntary commitment."

The facility's investigation included an unsigned, typed document titled, Abatement Plan, that read in part: On 04/11/23 at 12:00 PM Resident #127 was identified as being on an unauthorized

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absence away from the facility. The facility initiated elopement procedures and Code Green for Resident #127 at 12:10 PM when he could not be located within the facility. At 12:15 PM, local law enforcement was notified that Resident #127 was missing from the facility. At 1:00 PM, Resident #127 was located at a church in the neighborhood and brought back to the facility at 1:10 PM by law enforcement. Resident #127 refused to enter the facility and at 1:30 PM was taken by law enforcement to the hospital for an evaluation and possible involuntary commitment. Resident #127 returned to the facility from the hospital on 04/11/23 at 8:30 PM with no new orders or treatment.

A handwritten witness statement dated 04/11/23 signed by Nurse Aide (NA) #1 read in part, "I last saw Resident #127 around 10:30 AM. He was walking in the hallway as if he was going towards the dining room. After I passed Resident #127 in the hallway, I went on break. I came back around 11:00 AM - 11:15 AM and noticed he wasn't in his room or dining room. I went immediately and notified the nurse on duty that I didn't see him in either of those two places."

During a telephone interview on 04/05/24 at 11:58 AM, NA #1 confirmed she was Resident #127's assigned NA on 04/11/23 when he eloped from the facility and was told by Nurse #2 to watch him due to exit seeking behavior. NA #1 could not recall the exact time but said it was before lunch when she was doing her rounds and saw Resident #127 sitting out in the hall dressed in jeans, shirt, shoes and a jacket. She took a break and when she went back up the hall to check on him, she couldn't find him. She immediately told the Nurse, they both started

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looking for him everywhere and when they couldn't find him, Code Green was called which she described was the facility's missing person procedure. She stated law enforcement was also notified (did not know who called), every inch of the facility was checked and then staff started searching the facility grounds and surrounding neighborhood even knocking on doors to homes in the area and stopping cars on the main road. NA #1 stated at one point during the search she recalled some staff stating he had been talking about going back to where he used to live when he was homeless and some staff (could not recall who) got into their cars, went to the location, found him and brought him back to the facility. NA #1 stated it was around 1:00 PM when Resident #127 was returned to the facility but he wouldn't go back inside so he was taken to the hospital for evaluation and believed he returned to the facility later that same day. She did not recall Resident #127 having any visible injuries or appear in any distress when he was brought back to the facility. NA #1 stated Resident #127 could make his needs known at times but had a communication barrier due to him speaking very limited English. She stated there was a staff member at the time who was fluent in Spanish and could translate for them when they (NAs) couldn't understand what it was he was needing. NA #1 stated she had provided his care frequently prior to his elopement on 4/11/23 and he had never previously displayed exit-seeking behaviors or made any attempts to leave the facility.

A witness statement dated 04/11/23 signed by Nurse #2 read in part, "I last saw Resident #127 at around 10:30 AM going up the hall toward the dining room. About 11:00 AM - 11:30 AM the Nurse Aide asked where Resident #127 was and

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I went to look for him and could not locate him. We called a Code Green and all staff started searching the facility for Resident #127."

During an interview on 04/10/24 at 9:10 AM, Nurse #2 confirmed she was Resident 127's assigned nurse on 04/11/23 when he eloped from the facility. Nurse #2 recalled she had not been employed at the facility long and was still getting to know Resident #127 and his routine which was typically keeping to himself either sitting in his room, activity room or dining room. Nurse #2 stated she never really noticed him displaying exit-seeking before 04/11/23. Nurse #1 stated on the morning of 04/11/23, Resident #127 was verbalizing wanting to leave and was observed by staff going to the exit doors. She informed the Director of Nursing (DON) and Social Worker (SW) how Resident #127 was acting and was told to keep a close eye on him. Nurse #2 instructed the NAs to keep an eye on Resident #127 and everyone did the best they could to keep him in sight. Around lunchtime, Nurse #2 stated she went to look for Resident #127 to give him his medications and couldn't find him. She along with the NAs started looking in the facility and when they couldn't find him, the Administrator and DON were notified and Code Green was called. Nursing staff conducted a head count of all the residents and all staff started searching the facility premises looking for Resident #127. In addition, management staff left in their cars to search the surrounding neighborhood. Nurse #2 stated at the time of his elopement, Resident #127 had been refusing dialysis and was more confused. She was not really sure how he got out but thinks a visitor may have let him out the front door because he really didn't look like a typical resident. After Resident #127's elopement, the

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facility conducted elopement drills, re-education and instructed staff not to give the codes for the exit doors out to anyone who did not work at the facility.

During a telephone interview on 04/03/24 at 12:48 PM, Unit Manager #2 revealed she was no longer employed at the facility but was working on 04/11/23 when Resident #127 eloped. Unit Manager #2 recalled Resident #127 had refused to go to dialysis that day, she informed the Nurse Practitioner (NP) who ordered blood work and she (Unit Manager #2) went to Resident #127's room to draw his labs. She stated Resident #127 had started refusing to go to dialysis and when she provided him with education as to the importance of going he would still refuse, even when they tried different approaches to get him to go such as getting an outside transport company to take him because he didn't like the facility transport. Unit Manager #2 explained the more Resident #127 refused dialysis, the more confused he became and he started verbalizing he didn't want to be at the facility; however, he did not mention anything to her about wanting to leave the facility the morning of 04/11/23 when she drew his labs. Unit Manager #2 stated it was around 10:00 AM - 10:30 AM when she went into Resident #127's room and he was sitting on the side of his bed wearing a plaid shirt and jeans. She drew his labs and when she left his room, he was calm and in no distress. Unit Manger #2 stated she went on a break and then took the labs drawn to the hospital. She recalled she was only gone from the facility about 30 minutes when she was called and told Resident #127 was missing. She came back to the facility and everyone immediately started searching the facility and grounds for Resident #127. Unit

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Manager #2 stated she even walked around the perimeter of building but no one was able to locate Resident #127. Unit Manager #2 stated Resident #127 was later brought back to the facility by law enforcement but could not recall the time he returned. She recalled being informed Resident #127 had exited the building from the front entrance, she was not sure how, and walked to a church in the area but did not know the exact location or how far it was from the facility.

During an interview on 04/04/24 at 2:31 PM, the DON recalled she had only been employed about a month when Resident #127 eloped from the facility on 04/11/23 and she had never observed him actually attempt to leave the facility prior to that day. The DON stated she personally never heard him make comments about wanting to leave but was told by other staff that a few days prior to him leaving the facility on 04/11/23 he had made comments about wanting to go see his girlfriend. The DON recalled Resident #127 used a walker for ambulation and had an elopement alarm monitoring device attached to his walker. She was not sure why the order for the elopement alarm monitoring device was discontinued on 03/21/23 and explained when he returned from the hospital the order must not have been queued back into the system to show up as an active order. The DON stated when she saw Resident #127 the morning of 04/11/23, he wasn't acting any differently than normal and did remember seeing the elopement alarm monitoring device attached to his walker. She recalled at one point she had tried to get him to allow her to place it on his lower extremity, which only aggravated him because he knew what it was and what it meant and he had refused to wear it. When they later determined he was

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F 689	Continued From page 17 missing and conducted the facility-wide search, the DON stated they found the elopement alarm monitoring device on the floor in his room that looked like it had been "sawed" when removed from his walker which she described as torn with jagged edges. She stated facility staff searched everywhere in the facility as well as the facility grounds and when Resident #127 was not located, she (DON) drove around the neighborhood in her car to look for him. The DON did not recall how Resident #127 was able to get out of the facility but remembered being told (could not recall by who) that he had walked to some location in the area, was fed a meal and then taken to a local church where the Pastor spoke Spanish. She was not sure where Resident #127 had walked or how far the location was from the facility. The DON stated when Resident #127 was found and brought back to the facility by law enforcement, he wouldn't come inside the facility and she went with the Administrator to the Magistrates office to obtain paperwork for an Involuntary Commitment (IVC). She couldn't recall the exact time but stated Resident #127 was sent to the hospital for an evaluation but returned to the facility later that same day (04/11/23) which she stated frustrated her because she wanted him medically evaluated due to his frequent refusals to receive dialysis. The DON restated Resident #127 had a history of refusing dialysis and a few weeks after his elopement he was sent out to the hospital for evaluation and passed away. When asked if Resident #127 was safe to be outside unsupervised, the DON stated Resident #127 was able to ambulate with the use of his walker but had the tendency to have poor judgement and decision making skills.	F 689		

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F 689	Continued From page 18 During an interview on 04/24/24 at 2:57 PM, the Administrator explained Resident #127's primary language was Spanish which created a language barrier but he did have limited English and often made comments about wanting to go back where he used to live when he was homeless or go see his girlfriend in another state. The Administrator further explained Resident #127 had a history of refusing dialysis and as a result was deemed incompetent to make healthcare decisions and granted a court-appointed Guardian. She stated it was normal for Resident #127 to sit at the front exit doors because that was where he would wait for transportation to take him to dialysis when he was willing to go. She could not recall when but stated at one point, they had to start sending a staff member with him to dialysis because he would wander away from the dialysis center. On 04/11/23, the Administrator stated she was at the facility when notified Resident #127 could not be located, a Code Green was immediately called and a facility-wide search initiated but he could not be found. The Administrator recalled NA #1 was Resident #127's assigned NA on 04/11/23 and after she returned from break around 11:15 AM NA #1 didn't see Resident #127 in his room or dining room, she notified the nurse and they both started looking for him in the facility. When the nurse and NA #1 were unable to locate Resident #127 Code Green was called at 12:00 PM and law enforcement notified. The Administrator stated facility staff searched everywhere in the facility and then expanded the search to the outside grounds and perimeters. She added at the time of his elopement, Resident #127 did have an elopement alarm monitoring device but he had removed it and it was found on the floor of his room when they searched the premises. She recalled it was around 1:10 PM when Resident	F 689		

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F 689	Continued From page 19 #127 was located and brought back to the facility by law enforcement. She stated they had informed her Resident #127 walked to one of the neighborhood homes (not sure which one), he asked the homeowners for a ride and they took Resident #127 to a local church where the Pastor spoke Spanish and the Pastor had contacted law enforcement. When Resident #127 arrived back to the facility, he sat on the bench by the front entrance door refusing to go back inside. She explained a staff member employed at the time who was fluent in Spanish was talking to Resident #127 trying to convince him to go back inside the facility but he continued to refuse stating he would kill himself because he felt he was being locked up in the facility. At 1:30 PM, she went with the DON to the Magistrate's office to obtain IVC paperwork and he was sent to the hospital for evaluation but returned to the facility later that same day (04/11/23) and even though they felt he was too high functioning, he was moved to a room on the locked Memory Care Unit for safety. The Administrator stated after Resident #127's elopement, they did a root cause analysis and the best they could determine was some family members had learned the codes to the exit doors and must have let him out thinking he was a visitor because he didn't look like a typical resident of the facility. She stated they changed all the codes to the exit doors on 04/11/23 and facility staff were instructed not to give out the code to anyone and cover their hands when entering the code. The Administrator stated prior to his elopement, Resident #127 had been declining due to his frequent refusals of dialysis and sometime after returning to the facility on 04/11/23 he went on Hospice care, was sent out to the hospital in May 2023 and later passed away while at the hospital.	F 689		

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An observation of the facility grounds was conducted on 04/10/24 08:40 AM. The front of the building sat just off a main road that inclined and curved throughout a residential area with a speed limit of 35 miles per hour. When standing at the front entrance, there was border wall on the opposite side of a circular driveway that led to/from the parking lot located on the right side of the building. There was also a sidewalk that started at the front entrance of the facility and along the side of the building to the parking area. At the end of the sidewalk and driveway was an exit on the left out to the main road and on the right was the facility sign and the parking lot. Houses and/or trees bordered the opposite side of the parking lot, back and left side of the building.

An online website named Weather Underground was used to obtain the outside weather in the Hendersonville area on 04/11/23 which noted at 10:54 AM the temperature was 59 degrees Fahrenheit (F), at 11:54 AM the temperature was 63 degrees F, at 12:54 PM the temperature was 66 degrees F, and at 1:54 PM the temperature was 68 degrees F.

2. Resident #67 was admitted to the facility on 12/08/23 with diagnoses that included vascular dementia moderate with psychotic disturbance, bipolar disorder and hallucinations.

A physician order for Resident #67 dated 12/12/23 read in part, check elopement alarm monitoring device via testing machine every day.

A care plan initiated on 12/11/23 revealed Resident #67 has a diagnosis of vascular

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dementia, traumatic brain injury and behaviors which include, in part: wandering, rejecting care, packing up belongings and attempting to leave the facility using the fire exit button to open doors and becoming combative with staff when they attempt to prevent her from leaving. Interventions included one-to-one, every 15 minutes and/or every 30 minutes monitoring for safety as needed, attempt to redirect if/when she is resisting care, and monitor/report/document any mood changes to the nurse.

A care plan initiated on 12/11/23 revealed Resident #67 had a diagnosis of vascular dementia which could cause her cognition to vary throughout the day requiring assistance with decisions. Interventions included reorient to date, time and place if appropriate, provide redirection if/when Resident #67 made inappropriate actions and monitor/report/document any changes in cognition.

A care plan initiated on 12/12/23 revealed Resident #67 was at risk for elopement due to wandering, vascular dementia, traumatic brain injury, increased confusion at night, may be looking for family, thinks she works at the facility, and elopement alarm monitoring device to right ankle. Interventions included: may leave building when accompanied by staff or responsible adult, notify the Physician or Nurse Practitioner of exiting behavior, provide diversional activity PRN, and redirect from exit doors.

A care plan initiated on 12/12/23 revealed Resident #67 had impaired cognitive function and thought processes related to dementia and head injury. Interventions included for staff to cue, reorient and supervise Resident #67 PRN.

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An activities of daily living Care Area Assessment (CAA) associated with the Minimum Data Set (MDS) assessment dated 12/18/23 read in part, Resident #67 has had no documented behavioral issues since admission. Per staff interview, Resident #67 will wander throughout the unit and at times, will push on exit doors. Resident #67 does wear an elopement alarm monitoring device for added safety. She was transferred from another facility due to working at that facility and knowing the codes to open the facility's exit doors.

A physician order for Resident #67 dated 01/04/24 read in part, visually check elopement alarm monitoring device placement to right ankle every shift.

The quarterly MDS assessment dated 01/22/24 assessed Resident #67 with moderate impairment in cognition. Resident #67 displayed no behaviors, was independent with walking and used an elopement alarm daily during the MDS assessment period.

Review of Resident #67's February 2024 Treatment Administration Record (TAR) revealed physician orders for staff to check the elopement alarm monitoring device via testing machine every day shift and to visually check the elopement alarm monitoring device placement to her right ankle every shift. Both orders were initialed as completed daily per physician order. On 02/04/24, Resident #67's elopement alarm monitoring device was noted functioning and intact on the right ankle, each shift.

Review of Resident #67's medical record

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revealed an Elopement Assessment was completed on 03/06/24 that revealed Resident #67 was considered high risk for elopement. The assessment consisted of the following 4 sections:
Mobility Status: Is the resident physically capable of leaving the facility? The answer was marked as 'yes.'
Mental Status: Is resident alert and oriented times three? The answer was marked as 'no.'
Wandering Behavior: Does the resident wander within the facility or have a history of wandering? Does the resident verbalize or exhibit exit seeking behavior? Both questions were answered 'yes.'
History: Has there been previous history of attempted or actual elopement or unsafe wandering? The answer was marked 'yes.'

A staff progress note dated 02/02/24 at 5:34 AM written by Nurse #3 read in part, Resident #67 woke up at 4:00 AM and has been exit-seeking ever since. Resident #67 gathered all her belongings and said, "I'm going home" and no amount of redirection would convince her otherwise. All staff have been alert and monitoring her movement between front and back/side exit. Resident #67 also seems to be aware that if you consistently push the door it will open and has been observed several times leaning her weight on the door.

Telephone attempts for an interview with Nurse #3 on 04/05/24 at 10:16 AM, 04/10/24 at 10:16 AM and 04/10/24 at 12:14 PM were unsuccessful.

A staff progress note dated 02/02/24 at 7:51 AM written by Unit Manager #1 read in part, Resident #67 was found in the parking lot outside of the facility hiding between two cars. One-to-one immediate intervention initiated. Resident #67

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was assessed with no injuries. Family and Nurse Practitioner were notified.

During an interview on 04/10/24 at 10:48 AM, Unit Manager #1 recalled on 02/02/24 at shift change, around 7:00 AM, she was notified by Nurse Aide (NA) #2 and NA #3 that Resident #67 was found outside the building in the parking lot. Unit Manager #1 stated upon assessment, Resident #67 had no injuries or signs of distress and was placed on one-to-one staff supervision. She was unable to recall what Resident #67's response was when asked why she went outside. Unit Manager #1 explained Resident #67 always went to the exit doors trying to get out stating she wanted to leave to go see her boyfriend.

The facility's investigation included an unsigned, typed document titled, Abatement Plan, that read in part: Resident #67 exited the building on 02/02/24. Resident #67 had an elopement alarm monitoring device in place; however, the door did not alarm due to Resident #67 entering the code and a malfunction of the elopement alarm monitoring device sensor did not trigger the locking mechanism. Resident #67 was out of the facility for less than 5 minutes and was seen in the parking lot by staff and brought back inside the facility. Resident #67 had no injuries.

A witness statement dated 02/02/24 obtained from the Receptionist read in part, "Resident #67 was at the front door trying to push it open to get out when I arrived about 6:45 AM. She had all her clothes in bags. I went down to the nurses' station and had her moved from door before I left the door. When I was walking back up to my office, I saw NA #2 and NA #3 walking Resident #67 back down the hall. I had told them at the

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desk Resident #67 was up there trying to get out. They said she had been at the other door also during the night trying to get out. It was about 7ish when NA #2 and NA #3 found Resident #67 out in the parking lot. Resident #67 had let herself out."

During a telephone interview on 04/10/24 at 10:31 AM, the Receptionist recalled on 02/02/24 she had just arrived at the facility at approximately 7:00 AM and as she was coming through the front entrance, Resident #67 was standing by the door inside the facility, fully dressed with all her belongings packed in bags. The Receptionist stated she opened the door, making sure it closed behind her, and told Resident #67 she needed to go back to her room and not be standing by the door. The Receptionist went down the hall to clock in and then stopped by the nurses' station per her usual routine to see if there were any discharges. As she was walking back up the hall toward the front where her office was located, she saw NA #2 and NA #3 walking Resident #67 down the hall. She recalled the NAs stating Resident #67 had gotten outside and they had found her in the parking lot. The Receptionist stated it was only about 10 minutes after she saw Resident #67 at the door when the NAs had brought her back into the building. She was not sure how Resident #67 got out of the building because she (Receptionist) made sure the key pad was covered when she entered the code to the door and the door had closed securely before she left the area. The Receptionist explained Resident #67 used to be a NA at another facility and could figure out the codes to the exit doors. She further stated it was normal routine for Resident #67 to push on the exit doors or try to enter codes to get the doors

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open and staff provided her with frequent redirection throughout the day. She stated Resident #67 was always cooperative with staff redirection but due to her cognition, it wasn't long before she was right back at the exit doors. The Receptionist stated right after it was discovered Resident #67 had gotten out of the building, she sat by the door until it was fixed that day by the Maintenance Director. In addition, staff received immediate re-education on elopement process/procedure, not giving out the codes to the exit doors and making sure you covered your hand when entering the code.

A witness statement dated 02/02/24 that was obtained from Nurse Aide (NA) #4 read in its entirety, "NA #4 stated that he left at approximately 7:12 AM and as he was leaving the facility, he saw Resident #67 walking toward the front lobby."

Telephone attempts for an interview with NA #4 on 04/05/24 at 2:43 PM and 04/10/24 at 10:18 AM were unsuccessful.

A witness statement dated 02/02/24 that was obtained from NA #2 read in its entirety, "Was pulling out of front parking lot, stopped at facility sign and saw a woman squatting down between 2 cars. I was sorta dumfounded and I turned the car around. About this time, I think NA #3 saw her as well because she had started walking back up towards the front. NA #3 and I both got Resident #67 and walked her back into the building."

Telephone attempts for an interview with NA #2 on 04/03/24 at 8:15 AM, 04/05/24 at 2:15 PM and 04/10/24 at 10:15 AM were unsuccessful.

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A witness statement dated 02/02/24 that was obtained from NA #3 read in its entirety, "NA #3 was backing up her car and saw Resident #67. She stopped and assisted Resident #67 back into the facility along with NA #2 at approximately 7:15 AM."

During a telephone interview on 04/03/24 at 8:20 AM, NA #3 recalled when Resident #67 exited the building on 02/02/24 she was leaving work after her shift ended around 7:15 AM - 7:30 AM as was NA #2. She explained she was backing up her car in the parking lot when she saw NA #2 stop her car and get out. NA #3 stated she then noticed Resident #67 was also in the parking lot so she got out of her car to help NA #2 escort Resident #67 back inside building. NA #2 recalled Resident #67 was dressed in a long sleeved shirt, pants and shoes standing between 2 cars parked by the facility sign and when they told her she needed to get back inside the facility, Resident #67 went with them cooperatively. NA #3 recalled once Resident #67 was brought back into the facility, she was assessed by the Nurse and placed on one-to-one staff supervision. NA #3 was not sure how Resident #67 was able to get out of the building but she (Resident #67) was always trying to open the exit doors to get out and was not safe to go outside unsupervised so staff tried to keep a close eye on her.

A witness statement dated 02/02/24 written by the Director of Nursing (DON) read in its entirety, "I arrived at the facility at approximately 6:40 AM this morning. When standing at the nurses' station, the Maintenance Director told me Resident #67 was already prepared to go to Saluda that she had her bags packed. I walked

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F 689	Continued From page 28 toward my office and saw Resident #67 in her room, sitting on the bed. I asked her how her morning was and gave a good morning. Resident #67 responded 'morning' and said her day was 'ok so far.' Resident #67 never made any comment to me about leaving or going to Saluda. I proceeded to go to my office and began prepping for clinical morning meeting. The Receptionist came in my office shortly after. We spoke candidly then Resident #67 was mentioned. I told the Receptionist to watch up front. She stated she was going right back up front and would keep an eye out for Resident #67 while at the desk. The Receptionist then left and I continued my work. I was unaware Resident #67 had gone outside until Unit Manager #1 notified me that Resident #67 was found by NA #2 and brought back inside. The Administrator was immediately notified at 7:21 AM." During an interview on 04/03/24 at 2:31 PM, the Director of Nursing (DON) recalled on 02/02/24 she arrived at the facility at 6:40 AM and as she walked up the hall toward her office, Resident #67 was in her room. The DON stated she proceeded on to her office to get ready for the morning clinical meeting and around 6:45 AM the Receptionist came to her office to let her know that Resident #67 was up at the front door. The DON didn't recall seeing Resident #67 with any bags or other belongings when she redirected Resident #67 back to her room. The DON stated she did not know Resident #67 had gotten out of the building until notified by Unit Manager #1 and the DON immediately called the Administrator to let her know what had happened. She could not recall the exact time she was notified by Unit Manager #1 but stated Resident #67 was already back in the facility. The DON stated when she	F 689		

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F 689	Continued From page 29 went down to Resident #67's room, she was sitting on the side of the bed with no visible injuries or signs of distress and was laughing about getting outside. The DON recalled Resident #67 telling her she tried to leave because she wanted to go to Saluda (approximately 15 miles from the facility). The DON explained when Resident #67 was admitted to the facility, they were aware she had previous elopement attempts at the prior facility but Resident #67 had not tried to actually elope while at their facility, just made frequent comments that she wanted to return to Saluda. The DON explained when Resident #67 made those types of comments about wanting to leave, staff tried to monitor her closely by encouraging her to attend activities or the DON would have Resident #67 sit in the office to organize things for her since she used to be a NA. When asked if Resident #67 was safe to be outside unsupervised, the DON stated Resident #67 was able to ambulate independently but had the tendency to display poor judgement and decision making skills. During an interview on 04/03/24 at 10:54 AM, the Assistant Director of Nursing (ADON) recalled when she arrived to work around 8:00 AM to 9:00 AM on 02/02/24 she was informed that Resident #67 had gotten out of the facility by entering the code to open the front entrance exit door. She was also informed by NA #2 that Resident #67 had been at the exit doors during the night trying to open the doors. The ADON stated even with Resident #67 entering the code, the door should not have opened because Resident #67 had an elopement alarm monitoring device in place; however, they later determined the alarm on the front entrance exit door had malfunctioned and it was repaired by an outside company that same	F 689		

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day (02/02/24). The ADON explained Resident #67 used to be a NA and was very observant when it came to certain things such as trying to answer the door when she heard a knock or the doorbell. She explained it was normal for Resident #67 to wander throughout the facility but she did have some impulsivity and poor safety awareness which required staff to provide constant redirection. She added depending on the day, Resident #67 was either receptive to staff redirection or was so fixated on something she was unable to be redirected. The ADON stated based on the variation of Resident 67's cognition and poor safety awareness, she would not be safe outside unsupervised.

During an interview on 04/03/24 at 2:57 PM, the Administrator stated when Resident #67 was admitted to the facility, they were aware of her exit-seeking and elopement attempts at the previous facility. The Administrator explained Resident #67 used to work as a NA at the previous facility and they felt a transfer to a facility Resident #67 was not familiar with might derail her exit-seeking behavior. She stated upon admission, Resident #67 had intact cognition and because she was so high functioning they didn't want to trigger a decline so they decided against placing Resident #67 on the locked memory care unit opting instead to provide her with an elopement alarm monitoring device. The Administrator stated Resident #67 had a habit of packing up her belongings stating she wanted to go back to Saluda and would frequently go to the exit doors and play with the code box trying to figure out the code to open the doors. She stated the front entrance door was protected with an elopement alarm and even if Resident #67 put in the code to open the door it still should have

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locked due to her wearing an elopement alarm monitoring device but it didn't. The Administrator stated she tested the alarm on the front entrance door with an elopement device and all the lights were activated on the alarm panel indicating the door was alarmed but the door would still open and shouldn't have. She had an outside company come to the facility on 02/02/24 to repair the door alarm and they discovered the alarm panel had a bad chip. She added until the door was repaired, she had the Receptionist sit out in the hall by the front entrance to manually open/close the door and Resident #67 was put on on-to-one staff supervision. The Administrator stated when Resident #67 was brought back into the facility, she went to Resident #67's room to see her and Resident #67 had no visible injuries nor displayed any signs of distress. The Administrator stated staff were reeducated on the facility's elopement policy and instructed to be mindful of who was around when entering codes to open the exit doors.

The Maintenance Director was out on medical leave and unable to be interviewed.

An observation of the location where Resident #67 was found was conducted on 04/05/24 at 4:32 PM. The front of the building sat just off a main road that inclined and curved throughout a residential area with a speed limit of 35 miles per hour. When standing at the front entrance, there was border wall on the opposite side of a circular driveway that led to/from the parking lot located on the right side of the building. There was also a sidewalk that started at the front entrance of the facility and along the side of the building to the parking area. At the end of the sidewalk and driveway was an exit on the left to the main road

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and on the right was the facility sign. The facility sign was located at the end of the sidewalk approximately 125 feet from the front entrance door.

An online website named Weather Underground was used to obtain the outside weather in the Hendersonville area on 02/02/24 which noted at 6:54 AM the temperature was 37 degrees Fahrenheit (F) and at 7:54 AM the temperature was 39 degrees F.

The Administrator was notified of Immediate Jeopardy on 04/05/24 at 9:41 AM.

The facility provided the following Corrective Action Plan with correction dates of 04/12/23 for Resident #127 and 02/05/24 for Resident #67:

Allegation background: The Facility failed to provide supervision to prevent a resident with a court appointed guardian (resident #127) and a resident with impaired cognition (Resident #67) from exiting the facility unsupervised and without staff's knowledge.

Address the corrective action will be accomplished for those residents found to have been affected by the deficient practice:

Resident #127:
On 4/11/2023 Resident #127 was identified as being on unauthorized absence away from facility.

On 4/11/2023 at 12:10PM, facility initiated elopement procedures and "Code Green" when Resident #127 could not be located within the facility.

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On 4/11/2023 at 12:15PM, local law enforcement and Guardian were notified that Resident #127 was missing from facility.

On 4/11/2023 at 1:00PM, Resident was located at a church in the neighborhood next to the facility by local law enforcement.

On 4/11/2023 at 1:10PM local law enforcement arrived at the facility as Resident #127 was refusing to go into the facility.

On 4/11/2023 at 1:30PM Resident #127 was sent with law enforcement officers for involuntary commitment to local emergency department for assessment and evaluation.

On 4/11/2023 at 8:30PM Resident #127 returned to facility with no new orders or treatments.

On 4/11/2023 at 8:30PM Resident #127 was admitted to secure memory care unit for safety.

On 4/11/2023 Resident #127 was assessed by a licensed nurse upon return to facility with no injury noted or found.

On 4/11/2023 a, head to toe assessment was completed including ROM on resident #127 by licensed nurse with no injury noted.

On 4/11/2023 Education to all staff on Elopement initiated.

On 4/12/2023 new Brief Interview for Mental Status (BIMS) completed.

On 4/12/2023 fall assessment, Braden

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assessment, Pain assessment, Skin assessment completed.

On 4/12/2023 SSD assessment completed.

On 4/12/2023 Psych Consult requested by provider.

On 4/12/2023 Medication review requested by consultant pharmacist.

Resident #67:
On 2/2/24 Resident # 67 was found in the parking lot by staff of the facility and returned immediately inside of the facility.

On 2/2/2024 one on one was initiated on resident # 67 immediately upon entering the facility.

On 2/2/2024 Resident #67 was assessed by provider with no negative findings.

On 2/2/2024 Director of Nursing reviewed wandering assessments for all residents with no new findings.   On 2/2/2024 Psych Consult requested for resident #67.

On 2/2/2024 Director of Nursing requested Medication Review by the Consultant Pharmacist for resident #67.

On 2/2/2024 a head to toe assessment was completed by licensed nurse for resident #67 with no negative findings.

On 2/2/2024 fall assessment, BIMS and elopement assessments were completed for resident #67 by licensed nurse.

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F 689	Continued From page 35 On 2/2/2024 Director of Nursing/Designee re-educated all staff beginning on the elopement policy, prevention and the notification of Nursing Home Administrator and Director of Nursing. Education completed with all staff on 2/4/2024. On 2/2/2024 The Maintenance Director/Designee conducted an elopement drill over both shifts and reported findings to Nursing Home Administrator and Director of Nursing. No negative findings noted. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Resident #127: On 4/11/2023 Director of Nursing/designee completed new elopement assessments for all residents, no new residents were found to be at risk for elopement. On 4/11/2023 Director of Nursing/designee checked placement, function, and expiration date of all wander guard sensors on all residents with wander guards. No negative findings. Resident #67: On 2/2/2024 Director of Nursing checked placement, function, and expiration date of all residents with wander guards. No negative findings. On 2/2/2024 Social Worker audited wander guard binders which are located at each nurse station and at the reception desk to ensure they were correct and up to date. On 2/2/2024 Director of nursing or designee	F 689		

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completed new elopement assessments on all residents in facility to ensure no other residents were at risk. No new residents found to be at risk.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Resident #127:
On 4/11/2023 The Director of nursing/designee completed elopement assessments for all residents to identify any new residents at risk.

On 4/12/2023 Director of Nursing / designee educated all facility staff on Elopement policy, prevention and procedure. The education was completed on 4/12/2023.

On 4/12/2023 Director of Nursing / designee educated facility staff related to language and/or communication barriers. The education was completed on 4/12/2023.

On 4/11/2023 An Ad Hoc QAPI was completed.

Resident #67:
On 2/2/2024 DON/designee re-educated all staff beginning on the elopement policy and the notification of Nursing Home Administrator and Director of Nursing. Education completed on 2/4/2024.

On 2/2/2024 Director of nursing/ designee completed new elopement assessments on all residents in facility to ensure no other residents were at risk. No new residents found to be at risk.

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On 2/2/2024 Maintenance director replaced the wander guard door panel on the main entrance door and checks completed to ensure it is functioning properly.

On 2/2/2024 all staff were educated by Director of Nursing/designee on elopement prevention.

Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained:

Resident #127:
To monitor and maintain ongoing compliance the Director of Nursing/designee audited 3 resident charts weekly for 4 weeks then monthly for 2 months to ensure Elopement assessments were current/completed per policy. Audits began 4/11/2023.

The Director of Nursing/designee audited 3 resident Treatment Records weekly for 4 weeks then monthly for 2 months to ensure nursing staff are checking Wander Guards for proper function and placement and there are no issues with Wander Guards. Audits began 4/11/2023.

To monitor and maintain ongoing compliance the facility conducted monthly Elopement Drills on all shifts after initial elopement drill. The Maintenance Director/designee performed checks on all exterior or exit doors per manufacturer's specifications 5 times per week for 4 weeks then according to policy.

The decision was made to monitor and to take to QAPI on 4/11/2023.

Resident #67:

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F 689	Continued From page 38 To monitor and maintain ongoing compliance the Maintenance Director/designee performed checks on all doors with wander guard capability per manufacturer's specifications for proper functioning weekly for 8 weeks and then monthly. Audits began 2/2/2024. To monitor and maintain ongoing compliance, the Director of Nursing or Designee monitored 5 residents who are at risk for elopement weekly for 8 weeks and ensured wander guards are in place, functioning appropriately and that appropriate orders are in the Medication Administration Record to check for placement and function. Monitoring began on 2/2/2024. The decision was made to monitor and take to QAPI on 2/2/24. Residents who are newly identified for risk of elopement will have an elopement assessment completed by the licensed nurse and a wander guard will be applied as indicated. Alleged immediate jeopardy for Resident #67 removal date 2/5/2024. Tag Correction Date 2/5/2024. Alleged immediate jeopardy for Resident #127 removal date 4/13/23. The Corrective Action Plans were validated on 04/10/24 through observations, staff interview and record review. Observations of the facility exit doors revealed they were kept closed and locked and armed if applicable. Review of the facility monitoring tools revealed audits of the facility exit doors were completed with no	F 689		

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F 689	Continued From page 39 concerns identified. Staff education, elopement drills and monitoring of residents elopement alarm monitoring devices were completed with no concerns identified. The elopement book at the nurses' station contained information and pictures for each resident identified as high risk. Interviews conducted with staff on various shifts and departments revealed they received re-education related to elopement and residents with exit-seeking behaviors. Staff interviewed all confirmed they were instructed to cover their hands when entering the code to the exit doors and not to give out the code to anyone. Staff interviewed were able to describe the facility procedure for Code Green and confirmed they had participated in facility elopement drills. The corrective action plans were reviewed during QAPI meetings and the completion date of 02/05/24 was validated.	F 689		
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents'	F 726		4/10/24

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needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interviews, the facility failed to train and verify competency for cleaning and disinfecting a glucometer according to manufacturers' recommendations using an Environmental Protection Agency (EPA) approved disinfectant cloth between residents. Agency Nurse #1 was observed not cleaning and disinfecting a shared glucometer between use of two residents (Resident #57 and Resident #62). Agency Nurse #1 was interviewed and reported she was unaware residents requiring blood sugar monitoring had assigned individual glucometers and was unfamiliar with the EPA approved disinfectant wipe's manufacturer's guidelines for contact time. This was for 1 of 1 nursing staff.

The Immediate Jeopardy began on 04/03/24 when the failure to train and verify the competency of Agency Nurse #1 on the cleaning and disinfecting a glucometer resulted in the nurse's failure to clean and disinfect a glucometer between use of two residents. Immediate

F 726

•Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding.

F726 – Competent Nursing Staff
Step One: Director of Nursing/designee immediately educated Agency Nurse #1 on Glucometer cleaning and following the manufacturer’s guidelines for dwell time on the disinfectant wipes. This education was completed on 4/3/24.

Step Two: All current residents receiving finger stick blood glucose checks have the potential to be affected by this deficient practice. On 4/3/24, the Director of Nursing or designee audited all residents receiving finger stick blood glucose checks to ensure that each resident had their own assigned glucometer. To prevent this from

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Jeopardy was removed on 04/05/24 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity 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.

Findings included:

Cross refer to tag F-880:

Based on observations, staff interviews, and record review, the facility staff failed to disinfect a shared blood glucose meter (glucometer) between residents in accordance with manufacturer's recommended contact time for 2 of 3 residents whose blood glucose levels were checked (Resident #57 and Resident #62). This occurred while there was not a resident with known bloodborne pathogens in the facility. 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's instruction for disinfection, including the correct contact time, of the glucometer has the high likelihood of exposing residents to the spread of bloodborne pathogens.

In an interview with Agency Nurse #1 on 04/03/24 at 9:08 AM she stated this was her first shift at the facility. She stated she briefly wiped the glucometer in between checking the blood glucose for Resident #57 and Resident #62 and

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recurring: Director of Nursing/designee ensured that each resident had their own glucometer and that each glucometer was stored in their own individualized box labeled for that resident. Proper technique for disinfection and dwell time per manufacturer signage was also placed at nurse's stations for reference. Director of Nursing observed the next medication pass to ensure that glucometers were cleaned appropriately prior to performing finger stick blood glucose checks and that nurses were using individualized glucometers for each resident.

Step Three: To prevent this from reoccurring: Agency Nurse #1 received immediate education on proper cleaning of glucometer, including dwell time and use of individual glucometers. Director of Nursing or designee educated all licensed nursing staff, including all current agency nurses, on the Glucometer Use Policy, cleaning and disinfecting the glucometers before and after use by following the manufacturer's guidelines and using an Environmental Protection Agency registered disinfectant wipe per manufacturer's guidelines for appropriate dwell time. This education was completed on 4/4/24. The Director of Nursing of designee will educate all new agency and newly hired nurses on the Glucometer Use Policy, cleaning and disinfecting the glucometers before and after use by following the manufacturer's guidelines and using an EPA registered disinfectant wipe per manufacturer's guidelines for appropriate dwell time prior to the start of

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was not aware of any brand of glucometer that was required to be in contact with a cleaning/disinfection solution for a specified period of time. Agency Nurse #1 confirmed she had not received any training or education on how to disinfect glucometers from the facility prior to beginning her shift and was used to each resident having their own glucometer, which did not require cleaning in between uses unless there was visible blood on the glucometer. She stated she was not aware that each resident had their own glucometer and was unaware of any type of training/communication book was located at the nurses' station.

On 04/03/24 at 10:02 AM the Director of Nursing (DON) was informed that Agency Nurse #1 did not follow the manufacturer's guidelines for use of an EPA-approved disinfectant for the recommended contact time for a shared glucometer. The DON stated each resident had their own glucometer, but this was Agency Nurse #1's first day in the facility and she probably wasn't aware. She stated the facility provided orientation for new and agency staff, but she was not sure what the orientation entailed because the Assistant Director of Nursing (ADON) handled training for agency staff. The DON was asked for the training record from the facility or staffing agency for Agency Nurse #1 indicating she had been trained on how to disinfect glucometers.

Review of training and competency records for Agency Nurse #1 provided by the facility on 04/03/24 revealed there was no evidence the nurse had been trained on the procedure for cleaning and disinfecting a glucometer.

An interview with the ADON on 04/03/24 at 10:36

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their first shift.

Step Four: To monitor and maintain compliance, the Director of Nursing or designee will audit 5 observations of glucometer use to ensure compliance with manufacturer guidelines on cleaning, disinfecting and dwell time weekly for 12 weeks. The Director of Nursing or designee will interview 5 agency and/or facility staff regarding process for cleaning, disinfecting and dwell time to ensure competency weekly for 12 weeks. The Director of Nursing or designee will audit all new admissions prior to entry to facility for glucometer need and prepare individualized glucometer and storage box are labeled and ready for use upon new admission arrival. Findings of the audits will be reviewed with the Interdisciplinary Team at QAPI meetings, revising plan and interventions as indicated for 3 months.

Director of Nursing/Designee is responsible for this plan of correction.

Date of Compliance: 4/4/24

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AM revealed the facility recently changed the process of orientation for agency and facility staff. She stated the Scheduler and Business Office Manager assisted her with providing orientation training and each department head also provided education specific to their department. The ADON confirmed use of glucometer and glucometer disinfection were topics included in orientation but was unable to state who was responsible for completing the education. She stated agency staff should be aware of the policy and procedure for using and disinfecting glucometers and there should be a communication book at each nurses' station with information on how to use and disinfect glucometers that nursing staff could refer to. The ADON confirmed she had not provided any education regarding glucometer use and disinfection for Agency Nurse #1 prior to her beginning her shift on 04/03/24 and had not made her aware of the communication book at the nurses' station. The ADON was unable to describe how agency staff were notified of the communication book kept at the nurses' station. When asked to review the communication book for Agency Nurse #1's assigned hall the ADON was not immediately able to locate the communication book.

An interview with the Business Office Manager on 04/03/24 at 2:12 PM revealed she was not involved in the orientation process for agency staff.

An interview with the Scheduler on 04/03/24 at 2:16 PM revealed she was responsible for filling in gaps in the nursing staff schedule with agency staff when needed. She stated she was only responsible for obtaining licensing information

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and did not obtain any training information from staffing agencies. The Scheduler confirmed she did not provide any orientation training to agency staff.

The Administrator and Director of Nursing were notified of Immediate Jeopardy on 04/04/24 at 8:32 AM.

The facility provided the following credible allegation of Immediate Jeopardy removal:

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

Agency Nurse #1 completed a blood glucose check on Resident #57 and placed the blood glucose monitor she used back in the medication cart without cleaning the monitor. Agency Nurse # 1 was preparing to obtain Resident #62's blood sugar and picked up the same glucometer she had used on Resident #57 and wiped the glucometer with disinfecting wipe and failed to wait the 2-minute dwell time per manufacturer guideline of the disinfectant wipe and proceeded into the room of Resident #62 when the surveyor stopped the nurse because the glucometer had not been disinfected. Agency Nurse #1 had not checked any other resident's blood sugar prior to Resident #57.

On 4/3/2024 Agency Nurse #1 was educated by the Regional Director of Clinical Services on the cleaning and disinfection of glucose monitoring machines using the manufacturer's guidelines of the blood glucose monitor and that the disinfectant wipes are to be an EPA registered disinfectant and to follow the manufacturer's

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instructions for contact time.

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 4/3/2024 nurses and medication aides that were working on medication carts on 4/3/2024 were educated immediately by the Regional Director of Clinical Services on the cleaning and disinfection of glucose monitoring machines using the manufacturer's guidelines of the blood glucose monitor and that the disinfectant wipes are to be an EPA registered disinfectant and to follow the manufacturer's instructions for contact time.

On 4/3/2024 The Director of Nursing/Designee started education with all licensed nurses and medication aides on the cleaning and disinfection of glucose monitoring machines using the manufacturer's guidelines of the blood glucose monitor and that the disinfectant wipes are to be an EPA registered disinfectant and to follow the manufacturer's instructions for contact time. This education will be completed on 4/4/2024.

On 4/3/2024 Director of Nursing/designee started education for all licensed nurses and medication aides that each resident has been provided an individual blood glucose monitor labeled with residents' name and a non-porous container labeled with resident name and each resident's blood glucose monitor is to be kept separate and in each individual container and staff only use blood glucose monitor assigned to specific residents to obtain blood glucose. This education will be completed on 4/4/2024.

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On 4/3/2024 The Director of Nursing/designee started education with licensed nurses and medication aides on cleaning and disinfecting the blood glucose machines before and after each use by following the manufacturer's guidelines of cleaning and disinfecting the blood glucose monitor. The disinfectant wipes are to be an EPA registered disinfectant and staff were instructed to follow the manufacturer's instructions for contact time. This education will be completed on 4/4/2024.

On 4/3/2024 The Director of Nursing checked each medication cart and verified that each resident that requires blood glucose monitoring has an individual blood glucose meter that is labeled with the resident's name in non-porous container that is also labeled with each resident's name. There are 20 total residents that require blood glucose monitoring at this time.

On 4/3/2024 The Director of Nursing/Designee placed the policy on cleaning and disinfecting the blood glucose machine, the manufacturer's guidelines for cleaning and disinfecting the blood glucose monitor in the communication book at each nurses' station. Guidance to refer to the manufacturer's guidelines of the disinfectant wipes available for contact times and to ensure the wipes are an EPA registered agent effective against blood borne pathogens.

On 4/4/2024 The Director of Nursing placed a non-porous container labeled with each individual resident's name on each medication cart for each resident requiring blood glucose monitoring, each container contains a blood glucose monitor that is individually labeled with each resident's name.

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The Director of Nursing/Designee will educate all newly hired nurses and medication aides during orientation on the following:

1.) Policy and procedure for cleaning and disinfection of glucose monitoring machines before and after each use, following the manufacturer's guidelines for the machine.

2.) The dwell times for the EPA approved disinfectant for blood borne pathogens.

3.) Each resident has been provided an individual blood glucose monitor labeled with resident's name and a non-porous container labeled with resident name, which are located on each medication cart. Each resident's blood glucose monitor is to be kept separate in each individual container. Staff is to only use blood glucose monitor assigned to each specific resident to obtain blood glucose reading.

4.) Policy and procedure for cleaning and disinfecting the blood glucose machine as well as the manufacturer's guidelines for cleaning and disinfecting the blood glucose monitor can be found in the communication book at each nurse station.

The Director of Nursing/Designee will ensure all agency nurses have received the following education prior to working their first shift:

1.) Policy and procedure for cleaning and disinfection of glucose monitoring machines before and after each use, following the manufacturer's guidelines for the machine.

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2.) The dwell times for the EPA approved disinfectant for blood borne pathogens.

3.) Each resident has been provided an individual blood glucose monitor labeled with resident's name and a non-porous container labeled with resident name, which are located on each medication cart. Each resident's blood glucose monitor is to be kept separate in each individual container. Staff is to only use blood glucose monitor assigned to each specific resident to obtain blood glucose reading.

4.) Policy and procedure for cleaning and disinfecting the blood glucose machine as well as the manufacturer guidelines for cleaning and disinfecting the blood glucose monitor can be found in the communication book at each nurse station.

On 4/4/2024 The Nursing Home Administrator contacted the local Health Departments Communicable Disease Nurse to inform her of the F-880 Infection Control citation regarding cleaning and disinfection blood glucose monitors.

Alleged date of Immediate Jeopardy removal is 04/05/24.

The Immediate Jeopardy was removed on 04/05/24.

The facility's credible allegation of Immediate Jeopardy was validated on 04/10/24 through staff interview and review of in-service training records. Nurses and medication aides were able to verbalize they had received training on the proper procedure for disinfecting the glucometer before and after use with an EPA-approved

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F 726	Continued From page 49 disinfecting wipe and ensuring contact time was performed per manufacturer's guidelines before they were allowed to begin their shift. "Skill Competency for Point of Care Blood Testing Meter Disinfection and Use" for nurses and medication aides was reviewed, and all received satisfactory scores. The credible allegation was validated, and the Immediate Jeopardy was removed on 04/05/24.	F 726		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		4/10/24

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by:
Based on observation, staff interview, and record review the facility failed to ensure expired medications were removed from 2 of 4 locked medication carts (B hall and C hall).

The findings included:

1. An observation of the locked B hall medication cart on 04/04/24 at 10:14 AM with the Director of Nursing (DON) revealed in the cart was 1 opened bottle with 27 white calcium carbide tablets (a medication given for heartburn) with no dosage strength noted, that had an expiration date of 2/28/2024.

An interview with the Director of Nursing (DON) on 04/04/24 at 10:17 AM revealed her expectation was all expired medication to be removed from the medication B hall medication cart. She stated that the medication was probably overlooked because it was a home medication. She stated they are developing a more thorough system for medication date checks. She indicated that the staff assigned to the medication carts should check the dates before they administer medications and staff should be checking the expiration dates on all the medications in the medication carts periodically.

An interview on 04/04/24 at 10:14 AM with Medication Aide #1 revealed this was a medication Resident #5 was admitted with and did not take it any longer

Record review of the physician's orders dated 1/8/24 revealed calcium carbonate oral tablet 1250 milligrams (MG). Give 1 tablet by mouth every 4 hours as needed for indigestion,

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•Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding.

F761 – Label/Store Drugs & Biologicals
Step One: A blister pack of Omeprazole and a bottle of home medication, Calcium Carbonate, was observed to be expired and located on Medication Cart A. Medications were removed immediately.

Step Two: All current residents have the potential to be affected. The Director of Nursing or designee audited all medication carts storing medication and the medication storage room to ensure no other expired medication, home or pharmacy dispensed, were present. Any medication observed on the medications carts and medication storage room, including the Omnicell, that were expired were removed. This audit was completed on 4/8/24.

Step Three: To prevent this from reoccurring, the Director of Nursing or designee will educate all licensed nursing staff as well as all current agency staff and medication aides on removal of medication from the medication carts once they have been discontinued and returning medications removed from the medication carts to the designated bin for medication return. This education was completed by 4/10/24. The Director of Nursing or designee will educate all new

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heartburn.

2. An observation of the locked C hall medication cart on 04/04/24 at 10:42 AM with the DON revealed in the cart was 1 medication card with 18 Omeprazole 20 MG Capsules (a medication given for heartburn), that had an expiration date of 2/29/2024

An interview with the Unit Manager on 04/04/24 at 10:43 AM revealed the medication belonged to Resident #62 and he did not receive the medication. She stated that she tries to look through her medication cart once a shift for expired medications. She stated the medication must have been overlooked as she had not completed her daily medication cart check and she was not on the cart yesterday. She further stated it was the nurse who was assigned to the medication cart on each shift that was responsible for checking the medications expiration dates.

An interview with the DON at 04/04/24 at 10:45 AM revealed that her expectation was there be no expired medications on the medication cart. She stated that the medication must have been overlooked during the previous cart check. She further revealed that the order for the omeprazole was discontinued on 10/31/23 and that Resident #5 had and as needed order for the calcium carbide tablets.

Record review of the physician's orders revealed the omeprazole oral capsule delayed release 20 MG was discontinued on 10/31/2023.

An interview with the Administrator on 4/5/24 at 5:05 PM revealed that her expectation is all

F 761

hired licensed nursing staff, medication aides and all new agency staff on expectation of periodic checks of home-brought and pharmacy dispensed medications throughout their shift of expiration dates, as well as, checking the expiration dates at the time of dispensing medication.

Step Four: To monitor and maintain compliance, the Director of Nursing or designee will audit each medication cart, at least 5 different home-brought and/or pharmacy dispensed medications at random with each check weekly for 12 weeks. The Director of Nursing or designee will audit the medication carts to ensure discontinued medications have been removed and placed in the designated bin for return to pharmacy weekly for 12 weeks. Findings of the audits will be reviewed with the Interdisciplinary Team at QAPI meetings, revising plan and interventions as indicated for 3 months.

The Director of Nursing/designee is responsible for this plan of correction.

Date of Compliance: 4/10/24

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VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD HENDERSONVILLE, NC 28739

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F 761	Continued From page 52 expired medications be removed from the medication carts.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard expired food in 1 of 1 walk in coolers. These practices had the potential to affect food served to the residents. Findings included: An observation of the walk-in cooler on 04/01/24 at 09:43 AM revealed the following: A.) A container of shredded cheese with a preparation date of 2/11 and a use by date of 3/11.	F 812	"Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. F 812 Food Procurement- expired food Step One: On 4/1/2024 The Dietary Manager/designee immediately discarded all food that was expired from the walk in cooler.	4/10/24

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F 812	Continued From page 53 B.) A container of chili with a preparation date of 3/28 and use by date of 3/31. C.) A container of pureed fruit with a preparation date of 3/27 and a use by date of 3/30. An interview with the Cook/ Assistant on 04/01/24 at 09:44 AM revealed that their process was to check the walk-in cooler daily for expired food. She stated that her manager checked it last night and it must have just been overlooked. An interview with the Dietary Manager on 04/02/24 at 01:47 PM revealed that she and the Cook/ Assistant check the fridge every morning after breakfast for expired items. She revealed that she was unsure how the container of cheese was overlooked but her expectation was that all expired food be removed from the walk-in cooler. An interview with the Administrator on 4/5/24 at 5:05 PM revealed that her expectation was all expired food be removed from the kitchen walk-in cooler.	F 812	Step Two: All residents have the potential to be affected by this deficient practice. On 4/1/2024, the Dietary manager/designee completed a 100% audit of the kitchen, coolers and pantry to ensure no food was expired and all food was labeled and dated properly. Step Three: To prevent this from recurring, the Dietary Manager/designee educated all kitchen staff on food procurement policy, proper labeling and dating of foods and discarding of expired items in kitchen, pantry and coolers. Education was completed on 4-4-2024 with all dietary staff. The Administrator educated the Dietary Manager on Food Procurement, labeling and dating of food items and disposal of expired items in kitchen, pantry and coolers on 4-5-2024. Step Four: To monitor and maintain compliance, the Dietary Manager/designee will audit the walk in cooler 3 times per week to ensure no food is expired and all food is labeled for 12 weeks. Results will be taken to QAPI for review and revision as needed for the next 3 months. Dietary Manager/designee is responsible for this plan of correction. Date of Compliance: 4/06/2024	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and	F 867		4/10/24

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F 867	Continued From page 54	F 867		

monitoring.
A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and

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F 867	Continued From page 55	F 867		

systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

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F 867	Continued From page 56 §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions previously put in place following the infection control survey that occurred 01/04/21 in the area of Infection Prevention and Control	F 867	•Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding.	

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F 867 Continued From page 57

(F-880), complaint and recertification survey that occurred 07/01/21 in the areas of Food Procurement, Store/Prepare/Serve/Sanitary (F-812) and Infection Prevention and Control (F-880), complaint and recertification survey that occurred 01/20/23 in the areas of Food Procurement, Store/Prepare/Serve/Sanitary (F-812) and Infection Prevention and Control (F-880), and a complaint investigation that occurred 01/17/24 in the area of Free of Accident Hazards/Supervision/Devices (F-689). This failure was for 3 deficiencies that were originally cited in the areas of Infection Prevention and Control (F-880), Free of Accident Hazards/Supervision/Devices (F-689), and Food Procurement, Store/Prepare/Serve/Sanitary (F-812) and were subsequently recited on the current recertification and complaint and investigation survey of 04/10/24. The continued failure of the facility during five surveys of record in the same area showed a pattern of the facility's inability to sustain an effective QAA program.

Findings included:

This tag is cross referenced to:

F880: Based on observations, staff interviews, and record review, the facility staff failed to disinfect a shared blood glucose meter (glucometer) between residents in accordance with manufacturer's recommended contact time for 2 of 3 residents whose blood glucose levels were checked (Resident #57 and Resident #62). This occurred while there was not a resident with known bloodborne pathogens in the facility. Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and

F 867

F 867 QAPI/QAA Improvement Activities
Step One: The Administrator and Director of Nursing/designee re-initiated the audit tools for F812-Food Procurement, F880-Infection Control and F689- Free of Accidents due to receiving those citations during previous survey.

Step Two: On 4/5/24, Administrator and Director of Nursing/designee conducted 100% audit for all areas on new Plans of Correction for F812-Food Procurement, F880- Infection Control and F689- Free of Accidents to ensure the facility was in compliance.

Step Three: The RDCS educated the Nursing Home Administrator on following the QAPI process to maintain on going compliance, education was completed on 4-5-2024. New Plans of Corrections were written by the RDCS for facility to implement.

Step Four: The Administrator/designee will audit all of the audits for POC's weekly for 12 weeks to ensure audits are completed and facility remains in compliance. The Administrator will conduct an AD Hoc QAPI weekly for 12 weeks on Infection Control, Food Procurement and Accidents to ensure facility remains in compliance. Results of audits will be submitted to the QAPI committee for the next 3 months for further review and recommendations.

The Administrator/designee is responsible for this plan of correction.

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F 867	Continued From page 58 procedure. Failure to use an Environmental Protection Agency (EPA)-approved disinfectant in accordance with the manufacturer's instruction for disinfection, including the correct contact time, of the glucometer has the high likelihood of exposing residents to the spread of bloodborne pathogens. During the complaint and recertification survey conducted 01/20/23 the facility failed to implement their policy and procedure for assessing and preventing Legionella which had the potential to affect 72 residents. During the complaint and recertification survey conducted 07/01/23 the facility failed to ensure visitors wore Personal Protective Equipment (gowns, goggles, and masks) when interacting with 1 of 2 residents on a quarantine unit. During the infection control survey conducted 01/04/21 the facility failed to ensure dietary staff wore a face mask for 1 of 2 dietary aides. F689: Based on observations, record review and staff interviews, the facility failed to prevent a resident with a court-appointed guardian who required supervision with leave of absences, a previous elopement attempt, and wore an elopement alarm monitoring device (Resident #127) from exiting the facility unsupervised and without staff knowledge. The facility also failed to prevent a resident with impaired cognition who had a history of exit seeking behavior and wore an elopement alarm monitoring device (Resident #67) from exiting the facility unsupervised and without staff knowledge. The deficient practice was for 2 of 5 sampled residents reviewed for accidents. On 04/11/23, Resident #127 was last	F 867	Date of Compliance: 4/10/2024	

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seen in the facility at approximately 10:30 AM walking toward the dining room. At 11:15 AM Nurse Aide (NA) #1 went to look for Resident #127 and when Resident #127 was unable to be located inside the building, a Code Green (missing person) was called at 12:00 PM and a facility-wide search was conducted by staff which included the outside perimeter of the building and surrounding areas. At approximately 1:10 PM, Resident #127 was found at a location off facility property and brought back to the facility by law enforcement. On 02/02/24, Resident #67 was last observed in the facility at approximately 7:10 AM walking toward the front lobby. At approximately 7:15 AM, as NA #2 and NA #3 were leaving work they observed Resident #67 outside in the facility parking lot squatted down between two parked cars. Resident #67 was escorted back into the facility by NA #2 and NA #3. There was a high likelihood Resident #127 and Resident #67 could have suffered serious injury, harm or death when they were outside the facility unsupervised.

During the complaint investigation conducted 01/17/24 the facility failed to safeguard a cognitively impaired resident from an avoidable hazard when bed rails were used in conjunction with an alternating air mattress. The resident was found with no signs of life after experiencing a fall from a bed with bed rails in the up position. This occurred for 1 of 3 residents reviewed for accidents.
F812: Based on observations and staff interviews the facility failed to discard expired food in 1 of 1 walk in coolers. These practices had the potential to affect food served to the residents.

During the complaint and recertification survey

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F 867	Continued From page 60 conducted 07/01/23 the facility failed to maintain a clean vent cover for 1 of 2 ice machines. An interview with the Administrator on 04/10/24 at 12:44 PM revealed the QAA met monthly and reviewed any increase in areas such as pressure ulcers, reportables, falls, and any risk event. She stated the root cause of areas of concern were attempted to be determined and plans of action were developed. The Administrator stated she did not feel there was a breakdown in communication, or processes previously implemented as the situations were entirely different. She stated the QAA committee would be meeting later this month to review concerns identified during the current survey and evaluate the new processes put in place to determine if there were any areas that needed improvement. The Administrator stated she felt with the new processes implemented the facility would be able to achieve and maintain compliance.	F 867		
F 880 SS=J	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		4/25/24

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F 880	Continued From page 61 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880 Continued From page 62
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 in accordance with manufacturer's recommended contact time for 2 of 3 residents whose blood glucose levels were checked (Resident #57 and Resident #62). This occurred while there was not a resident with known bloodborne pathogens in the facility. 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's instruction for disinfection, including the correct contact time, of the glucometer has the high likelihood of exposing residents to the spread of bloodborne pathogens.

Immediate Jeopardy began on 04/03/24 when Agency Nurse #1 cleaned the glucometer between the two residents with an approved EPA disinfecting wipe but did not follow the manufacturer's recommendation for contact time. Immediate Jeopardy was removed on 04/05/24

F 880

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F880 – Infection Prevention and Control
Step One: Director of Nursing/designee immediately educated Agency Nurse #1 on Glucometer cleaning and following the manufacturer's guidelines for dwell time on the disinfectant wipes. This education was completed on 4/3/24.

Step Two: All current residents receiving finger stick blood glucose checks have the potential to be affected by this deficient practice. On 4/3/24, the Director of Nursing or designee audited all residents receiving finger stick blood glucose checks to ensure that each resident had their own assigned glucometer. To prevent this from recurring: Director of Nursing/designee ensured that each resident had their own glucometer and that each glucometer was

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F 880

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when the facility 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 "Glucometer/Point of Care Blood Testing and Disinfection Procedure" last revised 12/27/23 read in part as follows:

"Policy: Whether shared or assigned to a singular resident, blood testing meters will be disinfected between each use (before use the clinical staff should assume the meter is "dirty" and disinfect before use) according to manufacturer instructions and infection prevention guidelines.

Procedure:

- Wipe meter using friction with recommended type of germicidal wipe.
- Maintain visible wetness of meter for required "kill time" according to disinfectant instructions. Use multiple wipes if necessary. Do not reuse wipes".

The manufacturer's User Guide for the glucometer used at the facility included "Caring for Your System". These instructions read in part, "To minimize the risk of transmission of bloodborne pathogens, the cleaning and disinfection procedure should be performed as recommended in the instructions below. The

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stored in their own individualized box labeled for that resident. Proper technique for disinfection and dwell time per manufacturer signage was also placed at nurse’s stations for reference. Director of Nursing observed the next medication pass to ensure that glucometers were cleaned appropriately prior to performing finger stick blood glucose checks and that nurses were using individualized glucometers for each resident.

On 4/25/24 a root cause analysis was performed, it was determined that the nurse who was observed by the surveyor failed to disinfect the glucometer and wait the appropriate dwell time, was agency, it was her first day at the facility and she had not received glucometer training prior to taking the assignment.

Step Three: To prevent this from reoccurring: Director of Nursing or designee educated all licensed nursing staff, including all current agency nurses, on the Glucometer Use Policy, cleaning and disinfecting the glucometers before and after use by following the manufacturer’s guidelines and using an Environmental Protection Agency registered disinfectant wipe per manufacturer’s guidelines for appropriate dwell time. This education was completed on 4/4/24. The Director of Nursing of designee will educate all new agency and newly hired nurses on the Glucometer Use Policy, cleaning and disinfecting the glucometers before and after use by following the manufacturer’s guidelines

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cleaning procedure is needed to clean dirt as well as blood and other body fluids on the exterior of the meter before performing the disinfection. The meter should be cleaned and 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. We have validated [Brand Name] Germicidal Disposable Wipes for disinfecting the [Brand Name] meter". A list of additional products approved for cleaning and disinfecting the glucometer was provided by the manufacturer. The glucometer's manufacturer also noted, "Disinfectants were validated separately and only one cleaning/disinfection solution should be used on the device for the life of the device as the effect of using more than one cleaner/disinfectant interchangeably has not been evaluated".

Review of the manufacturer's guidelines and instructions for use of the EPA approved disinfectant wipe used by the facility specified a contact time of two minutes for disinfecting the [Brand Name] glucometer.

A review of a facility document titled "Diagnosis Report" dated 04/03/24 revealed there were no residents with known bloodborne pathogens residing in the facility.

A continuous observation of Agency Nurse #1 passing medication and performing blood glucose monitoring on 04/03/24 from 8:10 AM through 9:08 AM was conducted. At 8:10 AM Agency Nurse #1 checked Resident #57's blood glucose and placed the blood glucose monitor in the top drawer of the medication cart without disinfecting

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and using an EPA registered disinfectant wipe per manufacturer's guidelines for appropriate dwell time prior to the start of their first shift.
On 4/25/24 Facility Administrator spoke the state Quality Improvement Organization, Alliant, to review the current corrective action plan to ensure that the training includes glucometer cleaning and disinfection, including contact time.

Step Four: To monitor and maintain compliance, the Director of Nursing or designee will audit 5 observations of glucometer use to ensure compliance with manufacturer guidelines on cleaning, disinfecting and dwell time weekly for 12 weeks. The Director of Nursing or designee will interview 5 agency and/or facility staff regarding process for cleaning, disinfecting and dwell time to ensure competency weekly for 12 weeks. The Director of Nursing or designee will audit all new admissions prior to entry to facility for glucometer need and prepare individualized glucometer and storage box are labeled and ready for use upon new admission arrival. Findings of the audits will be reviewed with the Interdisciplinary Team at QAPI meetings, revising plan and interventions as indicated for 3 months.

Director of Nursing/designee is responsible for this plan of correction.

Date of Compliance: 4/25/24

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the monitor. At 9:08 AM Agency Nurse #1 quickly wiped the same blood glucose monitor used to check Resident #57's blood sugar with a [Brand Name] disinfecting wipe that was sitting on top of the medication cart. No friction was observed when Agency Nurse #1 wiped the glucometer. She removed the bottle of test strips from the cart, applied gloves, removed an alcohol pad and lancet from the cart, placed the test strip in the blood glucose monitor, and crossed the threshold of Resident #62's door to check his blood glucose. Less than one minute had elapsed. At 9:08 AM surveyor stopped Agency Nurse #1 from completing the blood glucose check for Resident #62 because Agency Nurse #1 failed to disinfect the blood glucose monitor in accordance with manufacturer's guidelines after use on Resident #57.

In an interview with Agency Nurse #1 on 04/03/24 at 9:08 AM she stated this was her first shift at the facility. She stated she briefly wiped the glucometer in between checking the blood glucose for Resident #57 and Resident #62 and was not aware of any brand of glucometer that was required to be in contact with a cleaning/disinfection solution for a specified period of time. Agency Nurse #1 confirmed she had not received any training or education on how to clean the glucometer prior to beginning her shift and was used to each resident having their own glucometer, which did not require cleaning in between uses unless there was visible blood on the glucometer. She stated she had not checked any other residents' blood glucose on 04/03/24 before checking Resident #57's at 8:10 AM. No timer was observed on Agency Nurse #1's medication cart.

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An interview with Unit Manager #1 on 04/03/24 at 9:13 AM revealed each resident had their own glucometer, but Agency Nurse #1 was probably not aware because that was her first shift at the facility. She stated each glucometer was different and required a different cleaning process and there was a binder at the nurses' station with information on how to clean different glucometers. Unit Manager #1 indicated the [Brand Name} disinfectant wipes sitting on top of Agency Nurse #1's medication cart were probably the wipes that should have been used for cleaning the glucometer after Resident #57's blood sugar check. She stated if the manufacturer of the [Brand Name] disinfecting wipes on the medication cart recommended a contact time of two minutes, then the glucometer should be in contact with the wipe for two minutes.

On 04/03/24 at 10:02 AM the Director of Nursing (DON) was informed of the concern related to the facility's failure to follow the manufacturer's recommended contact time for a shared glucometer. During the interview the DON was informed Agency Nurse #1 checked Resident #57's blood sugar, placed the glucometer in the top drawer of the medication cart without cleaning the glucometer, administered medications to two residents, removed the glucometer used to check Resident #57's blood sugar at 8:10 AM, wiped the glucometer briefly with a [Brand Name] disinfecting wipe, gathered additional supplies for checking a blood glucose, walked to Resident #62's room, and was stopped during the observation before the shared glucometer could be used for a second resident. The DON stated each resident had their own glucometer, but this was Agency Nurse #1's first day in the facility and

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she probably wasn't aware. She stated glucometers should be cleaned after each use with [Brand Name] disinfecting wipes, have a contact time of two minutes with the glucometer, and then air dry. The DON stated after the disinfecting process was complete, the glucometer would be ready for use again.

An interview with the Regional Director of Clinical Services on 04/04/24 at 5:57 PM revealed she had spoken with Agency Nurse #1, and Agency Nurse #1 confirmed she did not clean the glucometer after she checked Resident #57's blood glucose.

The Administrator and Regional Director of Clinical Services were informed of the Immediate Jeopardy on 04/03/24 at 5:57 PM.

The facility provided the following credible allegation of Immediate Jeopardy removal:

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

Agency Nurse #1 completed a blood glucose check on resident #57 and placed the blood glucose monitor she used back in the medication cart without cleaning the monitor. Agency Nurse # 1 was preparing to obtain Resident #62's blood sugar and picked up the same glucometer she had used on Resident #57 and wiped the glucometer with disinfecting wipe and failed to wait the 2-minute dwell time per manufacturer's guideline of the disinfectant wipe and proceeded into the room of Resident #62 when the surveyor stopped the nurse because the glucometer had not been disinfected. Agency Nurse #1 had not

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checked any other resident's blood sugar prior to Resident #57.

On 4/3/2024 Agency Nurse #1 was educated by the Regional Director of Clinical Services on the cleaning and disinfection of glucose monitoring machines using the manufacturer's guidelines of the blood glucose monitor and that the disinfectant wipes are to be an EPA registered disinfectant and to follow the manufacturer's instructions for contact time.

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 4/3/2024 Nurses and Medication Aides that were working on medication carts on 4/3/2024 were educated immediately by the Regional Director of Clinical Services on the cleaning and disinfection of glucose monitoring machines using the manufacturer's guidelines of the blood glucose monitor and that the disinfectant wipes are to be an EPA registered disinfectant and to follow the manufacturer's instructions for contact time.

On 4/3/2024 The Director of Nursing/Designee started education with all licensed nurses and medications aide on the cleaning and disinfection of glucose monitoring machines using the manufacturer's guidelines of the blood glucose monitor and that the disinfectant wipes are to be an EPA registered disinfectant and to follow the manufacturer's instructions for contact time. This education will be completed on 4/4/2024.

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F 880	Continued From page 69 On 4/3/2024 Director of Nursing/designee started education for all licensed nurses and medication aides that each resident has been provided an individual blood glucose monitor labeled with resident's name and a non-porous container labeled with resident name and each resident's blood glucose monitor is to be kept separate and in each individual container and staff only use blood glucose monitor assigned to specific residents to obtain blood glucose. This education will be completed on 4/4/2024. On 4/3/2024 The Director of Nursing/designee started education with licensed nurses and medication aides on cleaning and disinfecting the blood glucose machines before and after each use by following the manufacturer's guidelines of cleaning and disinfecting the blood glucose monitor. The disinfectant wipes are to be an EPA registered disinfectant and staff were instructed to follow the manufacturer's instructions for contact time. This education will be completed on 4/4/2024. On 4/3/2024 The Director of Nursing checked each medication cart and verified that each resident that requires blood glucose monitoring has an individual blood glucose meter that is labeled with the resident's name in non-porous container that is also labeled with each resident's name. There are 20 total residents that require blood glucose monitoring at this time. On 4/3/2024 The Director of Nursing/Designee placed the policy on cleaning and disinfecting the blood glucose machine, the manufacturer's guidelines for cleaning and disinfecting the blood glucose monitor in the communication book at each nurses' station. Guidance to refer to the	F 880		

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manufacturer's guidelines of the disinfectant wipes available for contact times and to ensure the wipes are an EPA registered agent effective against blood borne pathogens.

On 4/4/2024 The Director of Nursing placed a non-porous container labeled with each individual resident's name on each medication cart for each resident requiring blood glucose monitoring, each container contains a blood glucose monitor that is individually labeled with each resident's name.

The Director of Nursing/Designee will educate all newly hired nurses and medication aides during orientation on the following:

1.) Policy and procedure for cleaning and disinfection of glucose monitoring machines before and after each use, following the manufacturer's guidelines for the machine.

2.) The dwell times for the EPA approved disinfectant for bloodborne pathogens.

3.) Each resident has been provided an individual blood glucose monitor labeled with the resident's name and a non-porous container labeled with resident name, which are located on each medication cart. Each resident's blood glucose monitor is to be kept separate in each individual container. Staff is to only use blood glucose monitor assigned to each specific resident to obtain blood glucose reading.

4.) Policy and procedure for cleaning and disinfecting the blood glucose machine as well as the manufacturer guidelines for cleaning and disinfecting the blood glucose monitor can be found in the communication book at each nurse

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station.

The Director of Nursing/Designee will ensure all agency nurses have received the following education prior to working their first shift:

1.) Policy and procedure for cleaning and disinfection of glucose monitoring machines before and after each use, following the manufacturer's guidelines for the machine.

2.) The dwell times for the EPA approved disinfectant for bloodborne pathogens.

3.) Each resident has been provided an individual blood glucose monitor labeled with the resident's name and a non-porous container labeled with resident name, which are located on each medication cart. Each resident's blood glucose monitor is to be kept separate in each individual container. Staff is to only use blood glucose monitor assigned to each specific resident to obtain blood glucose reading.

4.) Policy and procedure for cleaning and disinfecting the blood glucose machine as well as the manufacturer guidelines for cleaning and disinfecting the blood glucose monitor can be found in the communication book at each nurse station.

On 4/4/2024 The Nursing Home Administrator contacted the local Health Departments communicable disease nurse to inform her of the F880 Infection Control citation regarding cleaning and disinfection blood glucose monitors.

Alleged date of Immediate Jeopardy removal is 04/05/24.

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The Immediate Jeopardy was removed on 04/05/24.

The facility's credible allegation of Immediate Jeopardy removal was validated on 04/10/24 through staff interview and review of in-service training records. Staff were able to verbalize that each resident had their own individual glucometer which was stored on the medication cart, glucometers were to be cleaned before and after each use according to manufacturer's guidelines with an EPA-approved disinfectant for the recommended contact time. Information regarding disinfecting blood glucose monitoring could be found in the Communication Book at each nurses' station. Observations were conducted of all medication carts and revealed each resident had their own individual glucometer which was labeled with their name and serial number of their assigned glucometer. Observations also confirmed EPA-approved disinfectant wipes were stored on each medication cart. The credible allegation was validated, and the Immediate Jeopardy was removed on 04/05/24.