STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	C 03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 03/10/25 through 03/14/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID: TGF411.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/10/25 through 03/14/25. Event ID: TGF411. The following intakes were investigated: NC00213482, NC00214202, NC00218814, NC00221480, and NC00227975. 3 of 19 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.80 at tag F880 at a scope and severity of J. Immediate Jeopardy began on 03/12/25 and was removed on 03/14/25.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		4/7/25

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

Electronically Signed | 04/04/2025

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F 550	Continued From page 1 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to maintain a resident's dignity by continuously utilizing a video and audio monitoring device in his room for 1 of 3 sampled residents reviewed for dignity (Resident #49). Resident #49 stated the video and audio device in his room did not make him feel good at all and he had to watch what he said around it because it was always	F 550	On 3/24/2025, the Social Worker interviewed and completed a questionnaire with Resident #49 and the Resident Representative, reviewing the use of the video and audio monitoring device. Based on the outcome of the interviews and questionnaire, the video and audio monitoring device was discontinued by the Medical Director on	

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F 550	Continued From page 2 watching him. Findings included: Resident #49 was admitted to the facility on 1/10/25 with diagnoses of type 2 diabetes mellitus, hypertension, and peripheral vascular disease. The admission Minimum Data Set (MDS) dated 1/17/25 revealed Resident #49 was cognitively intact and needed substantial assistance with transfers and walking. Resident #49 was not coded for any falls. Resident #49's care plan revised 1/30/25, indicated a problem area for falls and an intervention was the use of a video and audio monitoring device. A physician's order for the video and audio and monitoring device was written on 1/30/25 due to Resident #49's confusion and multiple falls. An observation on 3/10/25 at 3:55 PM revealed Resident #49 did not have a roommate and a video and audio monitoring device was visualized on a metal stand in Resident #49's room facing the bed. An interview with Resident #49 on 3/11/25 at 8:45 AM revealed he was aware of the video and audio monitoring device in his room but did not give written consent for its use. An interview with Resident #49 on 3/13/25 at 12:37 PM revealed he had the video and audio monitoring device in his room to watch him, so he didn't stand up and fall in his room. He explained	F 550	3/24/2025. On 3/25/2025, the Nurse Assessment Coordinator ensured that Resident #49 resident□s Care Plan reflected discontinuation of the video and audio monitoring device. On 3/28/2025 the Interdisciplinary Team (Therapy Director, Educator, Director of Nursing, Central Supply Manager/CNA, Administrator) met to discuss the resident□s psychosocial status associated with the past use of the audio and video monitoring device and it was determined that psychological services were not warranted. The Interdisciplinary Team will continue to evaluate Resident #49□s psychosocial needs to ensure they are addressed. On 3/21/2025 the Director of Nursing initiated an audit of 100% of all residents utilizing the video and audio monitoring device. The audit reviewed the reason for the video and audio monitoring device and if the Resident and/or Resident Representative voiced any concerns regarding dignity or privacy. On 3/31/2025 the Director of Nursing reviewed all residents who had not experienced a fall in 90 days and the reason for the video and audio monitoring device, with the Medical Director. On 4/2/2025 the Director of Nursing obtained orders from the Medical Director to discontinue the video and audio monitoring device orders for residents	

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F 550	Continued From page 3 the device will come on and speak to him and remind him to sit down and call for help. Resident #49 stated the device did not make him feel good at all and he couldn't even stand up before it started making loud noises. He stated that the video and audio monitoring device bothered him when it was first used but noted he had gotten used to dropping his pants and picking his nose in front of it. Resident #49 said he had to watch what he said in front of the device because it was always watching him. A second observation and second interview with Resident #49 was conducted on 3/13/25 at 4:12 PM. The surveyor asked the video and audio monitoring device for privacy and the computer screen read "Privacy Mode." The monitoring technician audibly explained through system speaker to wave at the device to turn off privacy mode. Resident #49 stated one day the staff rolled in the device and it had been in his room since. He did not know who the people were monitoring the device but explained he had talked to them before through the device. Resident #49 noted he was not aware he could ask for the system to be put in privacy mode and said only staff were able to ask for that. Resident #49 stated he felt he needed to watch what he said around the device because "it had ears." A review of the video and audio monitoring device's instructions found attached to Resident #49's device was conducted. The device included a camera with pan, tilt, and zoom capabilities, a monitor that enabled two-way video, and a speaker that provided two-way audio between the resident's room and viewing station. An interview with Nurse Aide (NA) #2 on 3/14/25	F 550	who had not experienced a fall in 90 days. On 4/2/2025 the Director of Nursing reviewed with Residents and Resident Representatives on how to engage the privacy mode, for any residents remaining on the video and audio monitoring device. On 4/2/2025 the Interdisciplinary Team reviewed residents remaining on video and audio monitoring device for any risk for psychosocial needs. The Interdisciplinary Team will continue to evaluate each resident□s psychosocial needs to ensure they are addressed. On 4/2/2025, the Nurse Assessment Coordinator ensured that all resident□s Care Plans reflected discontinuation of the video and audio monitoring device. On 3/14/2025, education was initiated by the Facility Nurse Educator to ensure that all staff providing care were aware of the steps to ensure that the resident□s dignity and privacy were not impacted when a video and audio monitoring device was initiated as an intervention. The education included the following: a review of the reason for the intervention; an explanation of how to place the device into privacy mode prior to starting care and how to engage monitoring after care was provided; if there were any concerns with privacy or dignity when the device was in use, that all staff providing care were aware if the Resident and/or Resident Representative voiced concerns related to the device, to report to the Director of Nursing and/or Administrative staff for	

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F 550	Continued From page 4 at 9:36 AM revealed the video and audio monitoring devices had been used about two years at the facility. She explained staff could ask for privacy mode when providing care for residents who had the devices in their room. NA #2 stated she was unsure when staff asked for "Privacy mode" in front of the device, if the resident and staff were actually receiving privacy, as she was unsure of what was visible on the other end of the camera. She stated family members and residents with the video and audio monitoring devices wouldn't know if there is a way to mute the device, so they are being watched in the room. NA #2 revealed she knew the monitoring technician could hear what was going on in the resident's room. An interview with Nurse #1 on 3/14/25 at 10:03 AM revealed Resident #49 had the video and audio monitoring device because he needed staff assistance, and he would often forget to call for assistance. She stated all of Resident #49's personal care was given in the bathroom, out of sight of the device. An interview with Nurse #2 on 3/14/25 at 11:13 AM revealed she managed the video and audio monitoring device unit offsite for the company. She stated she was an employee of the larger company and did not work on site at the facility. Her staff was comprised of many video and audio monitoring technicians who also worked for the company and were not on site at the facility. Nurse # 2 stated each device used in the facility had a plan for the corresponding resident and each monitoring technician would watch 10-12 video and audio feeds simultaneously at an offsite location. She stated the facility staff could ask for privacy and the device would go into	F 550	review for discontinuance, if needed. Any staff members who do not receive the training by 4/7/2025 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be required during new hire orientation. Beginning 4/2/2025, the Social Worker and/or designee will audit 100% of residents utilizing the video and audio monitoring device weekly for 12 weeks for privacy and dignity concerns. Any identified issues will be corrected immediately. Results of the audits will be shared with the Administrator on a weekly basis and with Quality Assurance Performance Improvement (QAPI) for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 550	Continued From page 5 "Privacy Mode" that lasted for 10 minutes. The video screen is blurred to the attendant during that time and staff is asked to wave to the device and the attendant would visualize the hand motion. Nurse #2 explained that the audio never turns off, but the device does not record and multiple feeds are viewed at once, so it would be hard to focus on a conversation. She stated the device used artificial intelligence to learn the movements of the resident and the video and audio monitoring technician would get an alert on their screen if a resident moved in a problematic way. Nurse #2 stated the technician would talk through the camera to the resident and if the resident was not redirected from the behavior, an alarm would sound from the device to alert staff in the facility. An interview with the Director of Nursing (DON) and Administrator on 3/14/25 at 2:34 PM revealed the video and audio monitoring device in Resident #49's room was continuously on for fall prevention, but the device did not record the feed. The DON stated she was not aware who was monitoring the devices but knew they were employees of the larger company, and they had background checks completed for their employment. The Administrator stated she was unaware Resident #49 was uncomfortable with the device in his room.	F 550		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	F 583		4/7/25

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F 583	Continued From page 6 §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to maintain privacy and obtain written consent for the use of a video and audio monitoring device in a resident's rooms for 1 of 3 sampled residents reviewed for privacy (Resident #49). A reasonable person would expect privacy in their living area and not be monitored continuously by a monitoring technician at an offsite location.	F 583	On 3/24/2025, the Social Worker interviewed and completed a questionnaire with Resident #49 and the Resident Representative, reviewing the use of the video and audio monitoring device. Based on the outcome of the interviews and questionnaire, the video and audio monitoring device was discontinued by the Medical Director on	

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F 583	Continued From page 7 Findings included: A review of the facility's policy entitled "Assignment and Use of Virtual Patient Observation (VPO) Greater Charlotte Market" dated 4/12/23 revealed the administrative supervisor or designee would bring the monitoring device to the unit as needed and would contact the VPO monitoring center to enroll the resident. The nurse and/or administrative supervisor would review the virtual sitter process with the resident, family, or caregiver present. Resident #49 was admitted to the facility on 1/10/25 with diagnoses of type 2 diabetes mellitus, hypertension, and peripheral vascular disease. The admission MDS dated 1/17/25 revealed Resident #49 was cognitively intact and needed substantial assistance with transfers and walking. Resident #49 was not coded for any falls. Resident #49's care plan revised 1/30/25, indicated a problem area for falls and an intervention was the use of a video and audio monitoring device. A physician's order for the video and audio and monitoring device was written on 1/30/25 due to Resident #49's confusion and multiple falls. A review of Resident #49's medical record revealed that no written consent for video or audio monitoring was obtained. An observation on 3/10/25 at 3:55 PM revealed Resident #49 did not have a roommate and a	F 583	3/24/2025. On 3/25/2025, the Nurse Assessment Coordinator ensured that Resident #49 resident□s Care Plan reflected discontinuation of the video and audio monitoring device. On 3/28/2025 the Interdisciplinary Team (Therapy Director, Educator, Director of Nursing, Central Supply Manager/CNA, Administrator) met to discuss the resident□s psychosocial status associated with the past use of the audio and video monitoring device and it was determined that psychological services were not warranted. The Interdisciplinary Team will continue to evaluate Resident #49□s psychosocial needs to ensure they are addressed. On 3/21/2025 the Director of Nursing initiated an audit of 100% of all residents utilizing the video and audio monitoring device. The audit reviewed the reason for the video and audio monitoring device and if the Resident and/or Resident Representative voiced any concerns regarding dignity or privacy. On 3/31/2025 the Director of Nursing reviewed all residents who had not experienced a fall in 90 days and the reason for the video and audio monitoring device, with the Medical Director. On 4/2/2025 the Director of Nursing obtained orders from the Medical Director to discontinue the video and audio monitoring device orders for residents	

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F 583	Continued From page 8 video and audio monitoring device was visualized on a metal stand in Resident #49's room facing the bed. An interview with Resident #49 on 3/11/25 at 8:45 AM revealed he was aware of the video and audio monitoring device in his room but did not give written consent for its use. He stated when he was admitted to the facility, his spouse signed all admissions paperwork and stated he was unsure if she gave written consent. Multiple attempts were made to contact Resident #49's spouse and were unsuccessful. A second interview with Resident #49 on 3/13/25 at 12:37 PM revealed he had the video and audio monitoring device in his room to watch him, so he didn't stand up and fall in his room. He explained the device will come on and speak to him and remind him to sit down and call for help. Resident #49 noted that the device also made a loud alarm noise to alert staff before he could stand up. A second observation and third interview with Resident #49 was conducted on 3/13/25 at 4:12 PM. The surveyor asked the video and audio monitoring device for privacy and the computer screen read "Privacy Mode." The monitoring technician audibly explained through system speaker to wave at the device to turn off privacy mode. Resident #49 stated one day the staff rolled in the device and it had been in his room since. He did not know who the people were monitoring the device but explained he had talked to them before through the device. Resident #49 stated he was not aware he could ask for the system to be put in privacy mode and said only	F 583	who had not experienced a fall in 90 days. On 4/2/2025 the Director of Nursing reviewed with Residents and Resident Representatives on how to engage the privacy mode, for any residents remaining on the video and audio monitoring device. On 4/2/2025 the Interdisciplinary Team reviewed residents remaining on video and audio monitoring device for any risk for psychosocial needs. The Interdisciplinary Team will continue to evaluate each resident□s psychosocial needs to ensure they are addressed. On 4/2/2025, the Nurse Assessment Coordinator ensured that all resident□s Care Plans reflected discontinuation of the video and audio monitoring device. On 3/14/2025, education was initiated by the Facility Nurse Educator to ensure that all staff providing care were aware of the steps to ensure that the resident□s dignity and privacy were not impacted when a video and audio monitoring device was initiated as an intervention. The education included the following: a review of the reason for the intervention; an explanation of how to place the device into privacy mode prior to starting care and how to engage monitoring after care was provided; if there were any concerns with privacy or dignity when the device was in use, that all staff providing care were aware if the Resident and/or Resident Representative voiced concerns related to the device, to report to the Director of Nursing and/or Administrative staff for	

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F 583	Continued From page 9 staff were able to ask for that. Resident #49 stated he felt he needed to watch what he said around the device because "it had ears." A review of the video and audio monitoring device's instructions found attached to Resident #49's device was conducted. The device included a camera with pan, tilt, and zoom capabilities, a monitor that enabled two-way video, and a speaker that provided two-way audio between the resident's room and viewing station. An interview with Nurse Aide (NA) #2 on 3/14/25 at 9:36 AM revealed the video and audio monitoring devices had been used about two years at the facility. She explained staff could ask for privacy mode when providing care for residents who had the devices in their room. She stated the device would have "privacy mode" on the screen when they used the word "privacy" and sometimes the monitoring attendant would speak over the device. She stated privacy mode usually lasted about 10 minutes and if care was completed before the end of 10 minutes, she would wave and speak to the device and privacy mode would be turned off. NA #2 noted the device would alarm loudly if a resident was not responding to the person monitoring the device. She explained she was unaware of who was monitoring the devices but knew it was not someone at the facility as staff was told the monitoring technicians were at an offsite location. An interview with Nurse #1 on 3/14/25 at 10:03 AM revealed Resident #49 had the video and audio monitoring device because he needed staff assistance, and he would often forget to call for assistance. Nurse #1 stated the device would alarm loudly if Resident #49 moved without	F 583	review for discontinuance, if needed. Any staff members who do not receive the training by 4/7/2025 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be required during new hire orientation. Beginning 4/2/2025, the Social Worker and/or designee will audit 100% of residents utilizing the video and audio monitoring device weekly for 12 weeks for privacy and dignity concerns. Any identified issues will be corrected immediately. Results of the audits will be shared with the Administrator on a weekly basis and with Quality Assurance Performance Improvement (QAPI) for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 583	Continued From page 10	F 583		

calling for assistance. She explained the staff would often get a phone call from the monitoring service at the nurse's desk after each alarm incident. She stated she did not ask for Privacy mode when working with Resident #49 as it did not include any personal care. She stated all of Resident #49's personal care was given in the bathroom, out of sight of the device. Nurse #1 stated she did not recall receive any formal training on the device.

An interview with Nurse #2 on 3/14/25 at 11:13 AM revealed she managed the video and audio monitoring device unit offsite for the company. She stated she was an employee of the larger company and did not work on site at the facility. Her staff was comprised of many video and audio monitoring technicians who also worked for the company and were not on site at the facility. Nurse # 2 stated each device used in the facility had a plan for the corresponding resident and each monitoring technician would watch 10-12 video and audio feeds simultaneously at an offsite location. She stated the facility staff could ask for privacy and the device would go into "Privacy Mode" that lasted for 10 minutes. The video screen is blurred to the attendant during that time and staff is asked to wave to the device and the attendant would visualize the hand motion. Nurse #2 explained that the audio never turns off, but the device does not record and multiple feeds are viewed at once, so it would be hard to focus on a conversation. She stated the device used artificial intelligence to learn the movements of the resident and the video and audio monitoring technician would get an alert on their screen if a resident moved in a problematic way. Nurse #2 stated the technician would talk through the camera to the resident and if the

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F 583	Continued From page 11 resident was not redirected from the behavior, an alarm would sound from the device to alert staff in the facility. An interview with the Director of Nursing (DON) and Administrator on 3/14/25 at 2:34 PM revealed the facility did not use written consents for the video and audio monitoring devices used in resident's rooms as the facility did not require consent. The DON explained the staff would ask for "Privacy Mode" when care was given near the device. She stated she was not aware who was monitoring the devices but knew they were employees of the larger company, and they had background checks completed for their employment. The Administrator explained each time one of the devices was used, an order was written and a plan for the device was put in place. She stated if any resident or responsible party refused the device, another plan would be put in place for the resident.	F 583		
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		4/7/25

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F 880	Continued From page 12 §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 §483.71 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 13 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, record review, and staff, Nurse Practitioner, and Medical Director interviews, the facility staff failed to follow the manufacturer's instructions for cleaning and disinfecting of a shared glucometer between resident usage for 2 of 2 residents whose blood sugar levels were checked (Resident #58, Resident #1). 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 instructions for disinfection of the glucometer potentially exposes residents to the spread of blood borne infections. There were two residents with a bloodborne pathogen in the facility at the time of the investigation. Immediate Jeopardy began on 03/12/25 when Nurse Aide #1 was observed performing blood glucose checks on residents using a shared glucometer without disinfecting per manufacturer's instructions. Immediate jeopardy was removed on 03/14/25 when the facility implemented an acceptable credible allegation of	F 880	On 3/12/2025, 100% of the blood glucose meters were cleaned and disinfected based on manufacturer□s guidelines by the Director of Nursing. On 3/13/2025, Resident #58 and Resident #1 were evaluated by the Medical Director. On 3/13/2025, Resident #58 and Resident #1□s Resident Representatives were notified of the infection control breach and provided information regarding the Medical Director□s evaluation. On 3/13/2025, the local Public Health Department was notified of the infection control breach by the Administrator. On 3/12/2025, Nurse Aide #1 was reeducated by the facility□s Nurse Educator on the manufacturer□s guidelines for cleaning and disinfecting blood glucose meters. Also, on 3/12/2025, Nurse Aide #1 was	

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F 880	Continued From page 14 immediate jeopardy removal. The facility will remain out of compliance at a D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the completion of education and monitoring systems are in place. Findings included: The undated glucometer manufacturer's instructions for cleaning and disinfecting indicated that the blood glucose monitoring system may only be used for testing multiple patients when standard precautions and the manufacturer's disinfecting procedures are followed. The meter should be cleaned and disinfected after use on each patient. Additional instructions were to use a purple top wipe or an orange top bleach wipe if the resident was on enteric precautions. Review of the facility policy "Glucometer Disinfection" revised in September 2021 read, in part, to clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. The procedure for disinfecting glucometers included: The manufacturer's guidelines are as follows: put on clean gloves, clean the glucometer as below with Germicidal Disposable Wipes ([purple top] for all non-contact enteric isolation) or Bleach Germicidal Wipes ([orange wipes] if resident on contact enteric isolation) - Place the meter on a level surface and ensure meter has been powered off - Obtain appropriate wipe and squeeze excess liquid from wipe - Wipe the meter to clean by gently wiping the outside of the meter and carefully wipe around the test strip port area, making sure that no liquid	F 880	provided competency validation by the facility□s Nurse Educator. On 3/13/2025 the Pharmacy Consultant conducted a 100% audit of all residents who required blood glucose checks and identified that thirty residents in the facility had the potential to be affected by the deficient practice. On 3/13/2025 a review of all residents to determine the number and room number of any residents with a blood borne pathogen was completed by the License Practical Nurse (LPN) Unit Coordinators, Registered Nurse Supervisor, and facility□s Nurse Educator. It was determined that two residents in the facility had a diagnosis of bloodborne pathogen. It was determined that both residents who had bloodborne pathogens do not have any blood glucose checks ordered and would not have any teammate use a blood glucose monitor to obtain any blood. On 3/27/2025 the Administrator ordered single-use blood glucose meters for each resident who required blood glucose monitoring and additional for back up supply. On 3/27/2025 the facility received the complete order for blood glucose meters for each resident who required blood glucose monitoring and additional for back up supply. On 3/28/2025 the Director of Nursing requested that the Medical Director review residents with active blood glucose check	

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F 880	Continued From page 15 enters the test strip port - Dry the meter thoroughly with a dry cloth or gauze. Visually verify that no solution is seen anywhere on the meter at the completion of cleaning - Use a fresh wipe to disinfect by gently wiping the outside of the meter three times horizontally and three times vertically and carefully wipe around the test strip port area, making sure that no liquid enters the test strip port. - Allow the surface of the meter to remain damp with the recommended contact time (two minutes for purple-top, 4 minutes for orange-top) - Dry the meter thoroughly with a dry cloth or gauze. Visually verify that no solution is seen anywhere on the meter at the completion of cleaning and disinfecting. - If further testing is not needed, return the meter to the base unit to charge the battery. The purple top wipes container which was located at the nurse's station read in part to disinfect nonfood contact surfaces to thoroughly wet surface, allow treated surface to remain wet for two minutes and let air dry. These wipes were an EPA-registered germicidal wipe and approved for bloodborne pathogen use. A continuous observation of Nurse Aide (NA) #1 was conducted from 03/12/25 at 11:46 AM through 12:00 PM and revealed the following: On 03/12/25 at 11:46 AM Nurse Aide #1 was observed in Resident #58's room. She stated she needed to go to the medication cart and gather necessary supplies. When she returned to Resident #58's room she was observed with a glucometer in her hand, alcohol swabs, and a lancet (used to stick the resident's finger). While	F 880	orders. On 3/29/2025 the Medical Director updated blood glucose check orders as deemed medically appropriate. On 4/3/2025, the Infection Control Consultant conducted an Infection Control Assessment and Response (ICAR) for General Infection Prevention and Control for Point of Care Blood Testing, to develop and implement a corrective action plan. On 4/3/2025, the Infection Control Consultant conducted a risk assessment. On 4/2/2025, the facility completed a Root Cause Analysis (RCA) with the assistance of the Corporate Performance Improvement, Corporate Infection Preventionist, Quality Assurance Performance Improvement (QAPI) Committee of the facility and Governing Body to develop the intervention plan. On 3/28/2025 the Administrator, Director of Nursing, Accreditation Coordinator, Pharmacy Consultant, Central Supply Manager, and Director of Nursing Services initiated development of the facility□s policy for single-use blood glucose meters, which must be stored in a manner that will protect against inadvertent use of the device for additional residents and cross contamination via contact with other meters or equipment. On 4/1/2025 the policy for single-use blood glucose meter was approved and established for the facility. On 4/1/2025, education was initiated by the Director of Nursing regarding the new	

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F 880	Continued From page 16 in the room a second glucometer was observed on Resident #58's bedside table, NA #1 stated the first glucometer on Resident #58's table would not scan his barcode (on the resident identification bracelet), so that was why she had to obtain the second glucometer from the medication cart. NA #1 obtained Resident #58's blood sugar with a reading of 135 at 11:48 AM. She then stacked the two identical glucometers on top of one another and threw away her trash, exiting the room with both glucometers in hand at 11:50 AM. Nurse Aide #1 went over to Resident #1 with both glucometers still in her hand and pushed the resident to her room. She told Resident #1 she was going to check her blood sugar and would be right back. Nurse Aide #1 then went to the medication cart and obtained alcohol swabs, a lancet, test strip and placed one of the glucometers onto the medication cart. NA #1 kept the other glucometer in her hand and scanned Resident #1's barcode. NA #1 was not observed disinfecting the glucometer and no disinfecting wipes were observed on the medication cart. At 11:54 AM Nurse Aide #1 entered Resident #1's room with one of the two glucometers that were in Resident #58's room. NA #1 began to obtain Resident #1's blood sugar, the surveyor stopped NA #1 and asked if the glucometer was the same glucometer used on Resident #58. NA #1 stated, "No, I am using the glucometer that was laying on his table, not the glucometer I used to get his blood sugar". NA #1 obtained Resident #1's blood sugar which was 244 at 11:57 AM and exited the room at 11:58 AM. At 12:00 PM the surveyor asked to see the glucometer history for the machine used to obtain	F 880	single-use blood glucose meters. The education included ensuring blood glucose meters were stored in a manner that will protect against inadvertent use of the device for additional residents and cross contamination via contact with other meters or equipment proper storage, infection control procedures for cleaning and disinfecting the blood glucose meters, and that only nurses would complete blood glucose checks. In addition, the Director of Nursing and/or designee completed competencies with all nurses. Any nursing staff who do not receive the training by 4/7/2025. (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be required during new hire orientation. On 3/12/2025 the Nurse Educator and/or designee conducted five audits weekly until single-use audit blood glucose monitors were initiated, monitoring storage and cleaning/disinfecting competencies of multi-use blood glucose devices. Beginning 4/4/2025 Unit Coordinator and/or designee will conduct five audits weekly for 12 weeks to audit single-use blood glucose monitors, monitoring storage and cleaning/disinfecting competencies with nurses. Any identified issues will be corrected immediately. Results of the audits will be shared with the Administrator on a weekly basis and with QAPI for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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Resident #1's blood sugar. The glucometer history revealed on 03/12/25 at 11:48 AM a blood sugar reading of 135 was obtained and at 11:57 AM a blood sugar reading of 244 was obtained. NA #1 was observed taking the glucometer to the nurse's station and obtaining a purple top wipe. She wiped the glucometer front and back quickly and immediately placed it onto the docking station to charge.

An interview occurred with Nurse Aide #1 on 03/12/25 at 12:00 PM. NA #1 stated she had taken one glucometer into Resident #58's room and sat it on his bedside table, however it would not scan so she had to go to the medication cart and obtain another glucometer. Once in Resident #58's room she had two glucometers and used one of them to obtain his blood sugar. She stated she placed both glucometers on top of one another and thought she had placed the one she used to obtain Resident #58's blood sugar on the medication cart however made a mistake and took it into Resident #1's room and also obtained Resident #1's blood sugar using the same machine without cleaning it in between residents. NA #1 stated she knew she was supposed to clean the glucometer in between residents and had been educated on it but just made a mistake. She also stated she knew there was a wet time for the cleaning of the glucometer and thought she had cleaned the glucometer for two minutes but did not time it. NA #1 stated she thought she could just let the glucometer "air dry" on the docking station.

An interview on 03/12/25 at 12:53 PM with the Infection Preventionist (IP)/ Director of Nursing revealed each resident household had 2 glucometers to use because not all residents

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admitted into the facility had their own glucometer. She stated the facility was very strict on disinfecting glucometers in between use of each resident and had just provided education on glucometer cleaning and disinfecting in January 2025. The IP stated the nurses and nurse aides should be using the disinfectant wipes after each use of the glucometer with a wet contact time of 2 minutes using two wipes and wiping the entire surface of the glucometer. After that, the nurses and nurse aide were to lay the glucometer on a towel and let it dry for a duration of 2 minutes. She stated NA #1 should have known the policy on cleaning and disinfecting the glucometers and followed it. The IP stated the negative outcome that could have occurred from not disinfecting the glucometer between resident use included the spread of bloodborne pathogens. She stated there were two current residents in the facility with a bloodborne pathogen and they were located in the same "neighborhood" of Resident #58 and Resident #1. The IP stated the facility did not have dedicated glucometers for each individual resident because the staff had been provided with education and training on how to disinfect the glucometers per manufacturer's instructions.

An interview conducted on 03/13/25 at 2:34 PM with the Nurse Practitioner (NP) revealed all nursing staff should be disinfecting the glucometers in between each resident and according to manufacturer's instructions. The NP stated there was a risk of spreading bloodborne pathogens by using the same glucometer on both residents without cleaning it per manufacturer instructions. She stated bloodborne pathogens could be spread by blood or bodily fluid if the nursing staff were not following standard precautions by cleaning the glucometer in

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between residents. She stated the risk of cross contamination could be high.

An interview conducted on 03/13/25 at 3:03 PM with the Medical Director (MD) revealed he felt using the same glucometer on multiple residents was an issue Administration needed to look into, including why it happened and preventative measures. The MD stated the staff could not use the same test strip for the glucometer on more than one resident. The interview revealed he felt using a test strip on multiple residents was the only likely way a bloodborne pathogen could be spread. The MD stated the nursing staff should be disinfecting the glucometer as directed by the facility.

An interview on 03/12/25 at 1:00 PM with the Administrator revealed that glucometers should be disinfected according to the manufacturer's instructions.

The Administrator was notified of the immediate jeopardy on 03/12/25 at 3:30 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;

During an observation on 3/12/25 at 11:46 AM, the Nursing Assistant failed to follow the manufacturer's guidelines for cleaning and disinfection of one blood glucose meter used for Resident #58 and Resident #1. Following the

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observation, this glucometer was cleaned and disinfected based on manufacturer's guidelines by the Director of Nursing. This failure provides the high likelihood for the spread of blood borne pathogens in the facility.

On 3/12/25, the Nursing Assistant was reeducated by the facility's Nurse Educator on the manufacturer's guidelines for cleaning and disinfecting blood glucose meters to include competency validation. On 3/12/25, the Nursing Assistant was provided competency validation by the Nurse Educator.

On 3/12/25, 100% of the blood glucose meters were cleaned and disinfected based on manufacturer's guidelines by the Director of Nursing. The manufacturer's guidelines are as follows: put on clean gloves, clean the glucometer as below with Germicidal Disposable Wipes ([purple top] for all non-contact enteric isolation) or Bleach Germicidal Wipes ([orange wipes] if resident on contact enteric isolation)
- Place the meter on a level surface and ensure meter has been powered off
- Obtain appropriate wipe and squeeze excess liquid from wipe
- Wipe the meter to clean by gently wiping the outside of the meter and carefully wipe around the test strip port area, making sure that no liquid enters the test strip port
- Dry the meter thoroughly with a dry cloth or gauze. Visually verify that no solution is seen anywhere on the meter at the completion of cleaning
- Use a fresh wipe to disinfect by gently wiping the outside of the meter three times horizontally and three times vertically and carefully wipe around the test strip port area, making sure that

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no liquid enters the test strip port.
- Allow the surface of the meter to remain damp with the recommended contact time (two minutes for purple-top, 4 minutes for orange-top)
- Dry the meter thoroughly with a dry cloth or gauze. Visually verify that no solution is seen anywhere on the meter at the completion of cleaning and disinfecting.
- If further testing is not needed, return the meter to the base unit to charge the battery.

On 3/13/25, Resident #58 and Resident #1 were evaluated by the Medical Director. On 3/13/25, the Resident #58 and Resident #1's responsible parties were notified of the infection control breach and provided information regarding the Medical Director's evaluation.

On 3/13/25 the facility's Pharmacy Consultant conducted a 100% audit of all residents who require blood sugar checks and identified that thirty residents in the facility have the potential to be affected by the deficient practice.

In addition, it was determined that two residents in the facility have a diagnosis of bloodborne pathogen. It was determined that both residents who have bloodborne pathogens do not have any blood sugar checks ordered and would not have any teammate use a blood glucose monitor to obtain any blood.

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 3/12/25 facility took immediate action by having the Nurse Educator review the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 22	F 880		

manufacture's guidelines and facility's cleaning grid for cleaning and disinfecting blood glucose meters to ensure that the guidelines were accurate and did not require changes.

The Nurse Educator provided education to all current nursing staff (Nursing Assistants and Nurses) to follow the manufacturer's guidelines for cleaning and disinfection of blood glucose meters, for staff competency. Any current nursing staff who do not receive education by 3/13/25 (due to FMLA, leave, etc.) will be required to complete education prior to working a scheduled shift. All nursing staff hired after 3/13/25 will be required to complete this training and education upon hire. The education will be required annually.

Beginning 3/12/25, the facility's Nursing Leadership team (Nurse Educator, Director of Nursing, Licensed Practical Nurse Unit Coordinators and Clinical Supervisors) will complete competency validation to monitor for compliance of all nurses and nurse aides following the manufacturer's guidelines for cleaning and disinfecting blood glucose meters. All currently employed nurses and nurse aides will have the competency validation completed by 03/13/25. Any employed nurses and nurse aides who have not received competency validation by 03/13/25 will receive competency validation by prior to their next working shift. All nursing staff hired after 03/13/25 will be required to complete the competency validation upon hire.

On 3/13/25, the facility Administrator notified the local Health Department regarding the infection control breach.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	C 03/14/2025

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F 880	Continued From page 23 Alleged IJ Removal Date: 3/14/25 On 03/13/25, the credible allegation of immediate jeopardy removal was validated by onsite verification through facility staff interviews. The interviews revealed all nursing staff had received education on provided education to follow the manufacturer's guidelines for cleaning and disinfection of blood glucose meters. Nursing staff (Nurses and Nurse Aides) were asked by educators to provide demonstration of glucometer use and cleaning during the education. The facility's in-service log and training material was reviewed. Additional observations were conducted of nursing staff obtaining residents blood sugars and disinfecting the glucometer per manufactures instructions. The IJ removal date of 03/14/25 was validated.	F 880		