EDGECOM PLACE AT THE VILLAGE AT BROOKWOOD

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 441</td>
<td>SS=D</td>
<td>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</td>
<td>F 441</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) 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.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

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 discomposable 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 discomposable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.
Continued From page 1

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and staff interviews, the facility failed to clean and disinfect a glucometer for 1 of 1 sampled resident observed receiving blood glucose monitoring (resident #256). Findings include:

The facility's policy, untitled and undated, read in part: "Cleaning between individual patient use: Assign glucose meters to individual patients whenever possible. Glucose meters shared among patients must be cleaned and disinfected between each patient use and PRIOR to returning to the tote for transport or docking...After each individual patient use, wipe the outside of the meter with a Super sani-wipe."

The Center for Disease Control (CDC) and Prevention Guidelines for Glucose Monitoring read in part: "Any time blood glucose monitoring equipment is shared between individuals there is a risk of transmitting viral hepatitis and other blood borne pathogens. Decontaminate environmental surfaces such as glucometers regularly and any time contamination with blood or body fluids occurs or is suspected. Glucose test meters approved for use with more than one person must be cleaned and disinfected following disinfection guidelines."

Accu-check or fingerstick blood sugar (FSBS) tests involve sticking a resident's finger for a blood sample, which is then placed on a strip. The strip goes into a glucose meter that reads the blood sugar level.
**STATEMENT OF DEFICIENCIES**

**PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 441</td>
<td>Continued From page 2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Resident #256 was admitted to the facility on 12/22/10 and readmitted on 9/4/12 with multiple diagnoses including diabetes. Review of the resident's clinical record revealed a physician order dated 9/4/12 for FSBS before meals and at bedtime.

Observation on 9/6/12 at 11:37AM revealed nurse #1 preparing to obtain a finger stick blood sugar for resident #256. Nurse #1 removed the glucometer from the tote where it was stored. The nurse wiped the resident's finger with an alcohol pad, obtained a blood sample by disposable lancet, and applied a drop of blood to the test strip. The nurse inserted the test strip into the glucometer. After reading the test results, the nurse removed and disposed of the used test strip, alcohol pad, and lancet. The nurse placed the glucometer back into the tote for storage. Nurse #4 did not clean or disinfect the glucometer after use.

In an interview on 9/6/12 at 11:50AM, nurse #1 stated the facility policy was to clean the glucometers thoroughly once daily at night. He stated the meter was cleaned during the day with a sani-wipe or other disinfectant if it was visibly soiled. Nurse #1 acknowledged he did not disinfect the glucometer after using it for resident #256.

In an interview on 9/6/12 at 2:08PM, nurse #1 stated he received training at least yearly. The nurse stated he had completed skills and competency training. Medication pass observations were completed routinely by the Director of Nursing (DON) and senior nurse.
### SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEG IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID TAG</th>
<th>PRECEDING STATEMENT OF DEFICIENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 441</td>
<td>Continued from page 3</td>
</tr>
</tbody>
</table>

In an interview on 9/6/12 at 3:01 PM, the DON stated she trained the staff upon hire and annually thereafter. Her training included medication pass and proper glucometer use. Medication pass observations were completed periodically by the pharmacist. The DON stated the facility policy was to disinfect the glucometer between residents. Her expectation was for the glucometer to be disinfected between each resident use and before returning it to the tote for storage.

### PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

<table>
<thead>
<tr>
<th>ID TAG</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 441</td>
<td>10/13/12</td>
</tr>
</tbody>
</table>

No residents were harmed during or after this finding. The glucometer was cleaned prior to being used on another resident. Additionally, on 9/6/12, the other 4 glucometers were inspected and deemed acceptable for use. Each of these was tagged appropriately with a sticker to indicate that they were cleaned since the last use. On 9/10/12, the nurse supervisors were informed by the DON to go over the policy and ensure compliance with it. The remaining nurses and CNAs were recertified on 10/12 and 10/13. New hires are trained in two ways: Nurses are trained in orientation through education and competency prior to starting on the floor for clinical orientation for 4 weeks. CNAs must go through the 4 hour course taught at ARMC for glucometer certification. All clinical staff must be retrained annually through competency and written materials. The nurse in question was counseled verbally on 9/6/12 and was directed to clean the unit immediately prior to using it on another resident. He was formally counseled on 10/2/12 and given a copy of the policy and signed that he understood the policy. As a result of this finding, the DON will perform 10 unannounced inspections per month for 3 months. At that time, it will be presented to the QA Committee on 1/17/13 for discussion. Depending on the findings, the inspections may or may be continued as per the committee's recommendation.
No residents were harmed during or after this finding. The glucometer was cleaned prior to being used on another resident. Additionally, on 9/6/12, the other 4 glucometers were inspected and deemed acceptable for use. Each of these was tagged appropriately with a sticker to indicate that they were cleaned since the last use. On 9/10/12, the nurse supervisors were in serviced by the DON to go over the policy and ensure compliance with it. New hires are trained in two ways: Nurses are trained in orientation through education and competency prior to starting on the floor for clinical orientation for 4 weeks. CNAs must go through the 4 hour course taught at ARMC for glucometer certification. All clinical staff must be retrained annually through competency and written materials. The nurse in question was counseled verbally on 9/6/12 and was directed to clean the unit immediately prior to using it on another resident. He was formally counseled on 10/2/12 and given a copy of the policy and signed that he understood the policy. As a result of this finding, the DON will perform 10 unannounced inspections per month for 3 months. At that time, it will be presented to the QA Committee on 1/17/13 for discussion.

Depending on the findings, the inspections may or may be continued as per the committee's recommendation.
**K000 INITIAL COMMENTS**

This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III (211) construction, one story, with a complete automatic sprinkler system.

The deficiencies determined during the survey are as follows:

**NFPA 101 LIFE SAFETY CODE STANDARD**

One hour fire rated construction (with ½ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

This STANDARD is not met as evidenced by:

- Based on observation on Thursday 10/11/2012 at approximately 9:00 AM onward the following was noted:
  - The soiled linen room corridor door to room 12018C did not close latch and seal.

**K029 SS=D**

No residents were affected by this door.

As a result of this finding, all other doors were checked and corrected where necessary. This particular door was repaired and tested on 10/12.

Checking doors has been increased in the PME program to monthly for the next 3 months and results will be discussed in Safety Committee. All members of the maintenance staff discussed these findings on 10/12 and ways to avoid them in the future.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K076</td>
<td>Continued From page 1</td>
<td>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</td>
<td>K076</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This STANDARD is not met as evidenced by: Based on observation on Thursday 10/11/2012 at approximately 6:00 AM onward the following was noted: 1) The oxygen storage was non-compliant, specific findings include: full and empty oxygen cylinders were stored together. If stored within the same enclosure, empty cylinders shall be segregated and designated (with signage) from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. [NFPA 99 4.3.5.2.2b(2)] (Storage Room 12017 1st floor) 2) In the oxygen cylinders in the oxygen storage room on second floor Rose Hall Oxygen cylinders were not properly chained or supported in a proper cylinder stand or cart. [NFPA 99 4.3.5.2.1b(27)]

42 CFR 483.70(a)

K104

NFPA 101 LIFE SAFETY CODE STANDARD

K104

No residents were affected by this finding. The empty storage containers were removed immediately and placed in the appropriate rack during the Life Safety Inspection. All nursing staff was reminded to follow the rules of storage and to read the sign above each rack. We have ordered new racks for the Rose Hall and they were shipped priority on 10/25. They will have signs placed above each indicating whether they are for full or empty cylinders. We will reiterate the new system on November 7 at the next staff meeting to remind them of the standard. The DON will inspect the storage rooms weekly for 3 months to ensure standard is being met and report through QA.
This STANDARD is not met as evidenced by:

- The smoke damper located in the smoke wall of Room 2 did not close upon activation of the fire alarm system.
- Large Damper located above switch was turned on when not needed.
- Based on observation on Thursday, 10/17/2012, at approximately 9:00 AM onward the following was noted:
  1. The smoke damper located in the smoke wall of Room 2 did not close upon activation of the fire alarm system.
  2. Large Damper located above switch was turned on when not needed.

K 144. Continued From page 2

K 104. Penetrations of smoke barriers by ducts are protected in accordance with NFPA 70, National Electrical Code 8.1.2.

K 147

K 147

No residents were affected by the hamper. The smoke damper was repaired on 10/17 and now close upon activation of the fire alarm system. The State Rep reviewed the manuals from the company who performed the inspection and repairs within the last 12 months. Maintenance does have a PME on the damper and will continue to check them. This team is reviewed through safety committees.

10/16

10/17/2012
K 000 INITIAL COMMENTS

This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III (211) construction, one story, with a complete automatic sprinkler system.

There were no Life Safety Code Deficiencies noted at time of survey.