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	345126	A. BUILDING _____ B. WING _____	C 04/04/2014

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MOUNT OLIVE CENTER	228 SMITH CHAPEL ROAD BOX 569 MOUNT OLIVE, NC 28365

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F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide hand hygiene for 1 of 1 sampled residents (Resident #71) whose hand care was observed. Findings included: Resident #71 was admitted to the facility on 01/17/14 with cumulative diagnoses of cerebrovascular accident (CVA), hemiplegia, and hand contractures. Resident #71's admission Minimum Data Set (MDS) dated 01/26/14 showed that Resident #71 was dependent on two people for hygiene and bathing. Review of the MDS Kardex Report for Resident #71 showed an undated handwritten note that the right hand finger separator be removed for AM (morning) care. In an observation on 04/03/14 at 10:10 AM Resident #71 was lying on the bed with a right hand splint in place. Nursing Assistant (NA) #1 was at the bedside and indicated that he had completed Resident #71's bath. When asked about the right hand splint he stated he had not removed it during the bath because he did not	F 312	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Mount Olive Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. F 312 1. Resident # 71 had his hand cleaned and fingernails trimmed and the splint cleaned by staff on 4/4/14. 2. There are nine other residents using splints and each of those residents was checked on 4/7/14 by MDS Nurse to assure proper personal hygiene and cleanliness of the splint. Education on proper splint care and provision of adequate ADL care was provided to staff on 4/18, 4/22 and 4/24/14 by the SDC. Staff will be required to perform return demonstrations to assess their skill level	4/29/14

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

Electronically Signed | 04/24/2014

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F 312	Continued From page 1 know how to take it off or put it back on. NA #1 then proceeded to remove the hand splint by detaching the hook and loop straps. Resident #71's right hand fingernails were noted to be long with a small amount of dark colored debris under the nails. There was an odor emanating from Resident #71's palm. NA #1 proceeded to wash Resident #71's right arm and hand with a white cloth. When the cloth was brought back from Resident #71's palm, a dark brown discoloration to the cloth was noted. In an interview on 04/04/14 at 11:25 AM Occupational Therapist (OT) #1 stated staff had been educated on how to take off and replace Resident #71's splint for morning care. He indicated if a staff member did not know how to take a splint off they could come and ask him. In an interview on 04/04/14 at 3:20 PM Nurse #4 stated splints should be removed during baths so hand hygiene could be provided. She indicated if an aide did not know how to remove a splint they could come to her or go to OT for instruction. In an interview on 04/04/14 at 4:50 PM the Director of Nurses (DON) stated she expected hand splints to be removed so the hands could be washed during care. She indicated she saw it as a problem that when Resident #71's hand splint was removed there was an odor and that brown material was removed.	F 312	with ADL□s and the splint care process. 3. Reeducation was provided to NA #1 on splint application and hand hygiene by DNS on 4/6/14. Nursing assistants received education on proper splint care. Charge Nurses, Nursing Supervisors, SDC, and DNS will make daily rounds to assure that residents with splints are receiving proper care. Facility has implemented the nursing assistant assignment worksheet. The licensed nurses will indicate what the CNA is expected to complete for each resident on that shift. The CNA will return the completed list to the nurse at end of the shift. Previous day results will be reviewed at clinical stand up and stand down. Admin nursing staff to monitor the ADL flow sheet at least weekly for documentation. Findings of any deficient practice will be reviewed and corrective measure noted to assure staff is completing tasks as assigned. 4. Results of these audits and findings will be reviewed at the QAPI meetings monthly for three months.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores	F 314		4/29/14

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F 314	Continued From page 2 does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to assess pressure ulcers upon discovery and readmission according to facility expectations, and failed to place nutrition interventions in place for 1 of 1 sampled residents (Resident #224) whose care to prevent and treat pressure ulcers was reviewed. Findings included: Resident #224 was initially admitted to the facility on 01/20/14, and was readmitted to the facility on 02/11/14 and 03/03/14 after hospitalizations, and was discharged to the hospital once again on 03/22/14. The resident's documented diagnoses included gastrostomy, dysphagia, systemic inflammatory response syndrome, pseudomonas infections, and quadriplegia. The resident's 01/20/14 nursing assessment documented her skin was intact. The resident's January 2014 treatment administration record (TAR) documented weekly skin checks were to be completed by a hall nurse for Resident #224 on 01/21/14 and 01/28/14, but these were not initialed off as being completed. On 01/23/14 "Potential for skin breakdown related to: immobility, incontinence, chronic progressive disease, hemiplegia" was identified as a problem	F 314	F-314 1. Resident #224 has not returned to the facility. 2. All residents of the facility have the potential to be affected by this practice. Unit Managers and/or DNS to complete skin assessment on all residents in the center and ensure treatment orders are in place and being followed. Education for licensed nurses regarding the admission/re admission process completed on 4/11/14 for all shifts by the DNS for assessing the resident for possible skin integrity issues. 3. Two licensed nurses will perform a head to toe assessment at the time of admission/readmission. Unit Manager/DNS to monitor new admissions/readmission medical record to ensure that if resident has skin integrity concerns that there is an order to treat. The RD will assess all resident with pressure ulcer to ensure they are being provided appropriate nutritional intervention. 4. Unit Manager/DNS to monitor new admissions/readmissions weekly for 3 months. Unit Manager to monitor TAR weekly to ensure weekly head to toe	

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F 314	Continued From page 3 on the resident's care plan. Interventions included weekly skin assessment and observation of skin each shift to alert unit supervisor of skin changes/breakdown so treatment orders could be obtained. Review of interdisciplinary progress notes documented Resident #224 was sent to the hospital on 01/28/14, and was later readmitted to the nursing home on 02/11/14. The resident's 02/11/14 nursing assessment documented she was readmitted with multiple bruises and a blister on her right buttock. Nursing assistant (NA) #2 completed an Early Warning Tool on 02/17/14 (Monday) which documented Resident #224 developed an open area on the skin of her right buttock. At 2:42 PM on 04/03/14 NA #2 stated on 02/17/14 there was only an open area on Resident #224's right buttock. She reported the area was missing the top layer of skin. NA #2 commented she completed the tool used by the facility (the Early Warning Tool) to communicate with the hall nurse the change in the resident's skin integrity. 02/18/14 lab results documented Resident #224's albumin was low at 3 grams per deciliter (g/dL) with the reference range being 3.5 - 5.2 g/dL and her total protein was low at 5.4 g/dL with the reference range being 6 - 8.3 g/dL. Review of interdisciplinary progress notes, physician orders, and skin integrity reports revealed no assessment of Resident #224's skin breakdown and no physician order for treatment until 02/20/14 (Wednesday) when Nurse #1	F 314	assessment is being completed and that treatments are being completed as ordered. Results will be monitored by the QAPI Committee monthly for 3 months.	

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F 314	Continued From page 4	F 314		

documented in a nurse's note, "...Open wounds to right and left buttocks. Serosanguineous drainage. Clean with NS (normal saline), applied hydrogel, and covered with boarder gauze..."

At 3:20 PM on 04/03/14 the unit supervisor stated it was not acceptable that three days elapsed between identification of Resident #224's new pressure ulcer and the subsequent treatment order and assessment of the wound. She reported it was the responsibility of the hall nurse to write a detailed description of new ulcers upon receipt of an Early Warning Tool, and to select a treatment based on the facility's ulcer protocol. She explained that unit supervisors measured ulcers and conducted follow-up assessments weekly thereafter. According to the unit supervisor, Nurse #1 was supposed to initial the Early Warning Tool when she acted upon it, but she reported this was not done. She stated she had concerns because from between the time the Early Warning Tool was completed and the assessment and treatment orders were documented three days later Resident #224 went from having one ulcer to two ulcers.

At 3:55 PM on 04/03/14 Nurse #1 stated she thought she assessed the breakdown on Resident #224's buttocks the same day she received the Early Warning Tool. She reported she put a treatment in place, but it was up to the unit supervisor and physician to review and make sure the treatment was acceptable. According to Nurse #1, when she first assessed the new pressure ulcers which the resident developed they were open areas present on bilateral buttocks.

At 4:52 PM on 04/04/14 the director of nursing

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(DON) stated it was not acceptable that three days elapsed between identification of Resident #224's new pressure ulcer and the subsequent treatment order and assessment of the wound.

On 02/21/14 "Resident has impaired skin integrity r/t (in regard to) pressure ulcer on right and left buttocks secondary to: immobility, incontinence, chronic progressive disease" was identified as a problem in the resident's care plan. Interventions to this problem included treatment as ordered and registered dietitian (RD) evaluation as needed.

A hospital discharge summary documented Resident #224 was hospitalized from 02/21/14 until 03/03/14.

Hospital labs drawn on 02/21/14 documented Resident #224's albumin level was low at 2.7 g/dL with the reference range being 3.2 - 4.6 g/dL and total protein level was low at 6 g/dL with the reference range being 6.1 - 8 g/dL.

A 03/03/14 interdisciplinary progress note documented, "...Open areas noted rt (right) buttocks granulation and eschar present in wound bed. Open area left buttocks granulation tissue present. Rt lower buttocks open area noted. Outside right foot unstageable noted...."

At 3:20 PM on 04/03/14 the unit supervisor stated the assistant director of nursing (ADON) measured Resident #224's buttock ulcers on 03/04/14, but these measurements were documented on scrap paper. She reported the ADON no longer worked in the facility, but before leaving she communicated to the Minimum Data Set (MDS) nurses that on 03/04/14 Resident

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#224 had stage II ulcers to her bilateral buttocks, the right measuring 5.7 x 2.0 centimeters (cm) and the left measuring 3.2 x 1.9 cm.

On 03/05/14 physician orders were obtained to clean the bilateral buttocks with normal saline/ apply hydrogel/cover with boarder gauze and to apply sure prep to left lateral aspect of foot.

Resident #224's 03/10/14 Admission MDS did not capture her cognition, but documented the resident's decision making skills were severely impaired. The assessment also documented the resident had two stage II pressure ulcers.

A 03/10/14 Medical Nutritional Assessment, completed by the facility's registered dietitian (RD), documented Resident #224's total caloric intake was provided by Jevity 1.5 continuously running at 45 cubic centimeters (cc) per hour. She documented the resident's current weight was 133 pounds or 60 kilograms, and the formula provided 68.9 grams of protein daily. The RD also documented the resident had multiple open areas to her buttocks and an unstageable ulcer to her right foot. The RD's assessment documented, "TF (tubefeeding) is adequate to meet protein and calorie needs."

At 2:43 PM on 04/04/14 the facility's RD stated she went by a facility protocol in determining resident protein needs in conjunction with promoting the healing of pressure ulcers. She reported that if a resident had a stage IV, unstageable, deep tissue injury, or multiple pressure ulcers the protocol specified that the resident's weight in kg was to be multiplied by 1.5 to determine the grams of protein required daily (for Resident #224 who weighed 60 kg x 1.5, her

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protein needs were 90 grams of protein daily). The RD commented, after reviewing her 03/10/14 assessment, she should have added protein powder to the resident's tubefeeding regimen since her formula only provided 68.9 grams of protein, and the wound healing protocol suggested receiving 90 grams of protein daily. Also, after reviewing the resident's medical record, the RD stated Resident #224 did not receive any nutritional supplements (other than her formula) during her stay which would have aided with the healing of wounds.

Only Skin Integrity Reports for Resident #224's right and left buttocks were present in her medical record. The first measurements and assessments of the bilateral buttock ulcers were on 03/14/14. The reports documented the right buttock ulcer was a stage III which measured 2.1 x 1.4 cm with 50% slough and 50% granulation tissue and minimal serosanguineous drainage. The reports documented the left buttock ulcer was a stage II which measured 2.5 x 1.2 cm with greater than 75% epithelial tissue and minimal serosanguineous drainage.

At 4:52 PM on 04/04/14 the DON stated she expected initial and weekly wound assessments to include measurements, descriptions of wound beds, staging information, and documentation about possible drainage, odor, undermining, and pain. She reported that, after reviewing wound documentation, a complete assessment of Resident #224's bilateral buttock wounds was not accomplished until 03/14/14, even though the resident was readmitted to the facility on 03/03/14. The DON remarked she had concerns because treatment for pressure ulcers was not ordered until 03/05/14 when the resident was

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F 314	Continued From page 8 readmitted on 03/03/14, and per MDS documentation, it appeared the resident's right buttock ulcer deteriorated in the time between 03/03/14 and 03/14/14. She was unable to find assessment documentation concerning the resident's other wounds which were described in the resident's 03/03/14 re-admission interdisciplinary progress note (unstageable ulcer to the right foot and ulcer to right lower buttocks). According to the DON, the facility depended on the expertise of the RD to recommend nutritional supplements or diet/formula changes which might promote wound healing. She commented she expected the RD to follow facility protocol in calculating resident protein needs.	F 314		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide a favorite food with meals which was an intervention for 1 of 3 sampled residents (Resident #6) reviewed for significant weight loss. Findings included:	F 325	F-325 1. The diet for resident #6 has been reviewed and staff is assuring that his ice cream is included on his tray as specified.	4/29/14

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F 325	Continued From page 9 Resident #6 was admitted to the facility on 12/01/00 and readmitted on 04/27/05. The resident's documented diagnoses included quadriplegia, Parkinson's disease, dysphagia/aphasia, and dementia. A 12/12/13 Medical Nutrition Therapy Assessment, completed by the registered dietitian (RD), documented Resident #6 was receiving a puree diet with large portions and scheduled snacks twice daily. His meal intake was documented as 100%. The resident's 12/14/13 Annual Minimum Data Set (MDS) documented his short and long term memory was impaired, his decision making skills were significantly impaired, he was 5'4" and weighed 120 pounds, he required assistance from staff with meal set-up only, and he had experienced no significant weight loss in the last 30 or 180 days. The resident's Weight Summary documented he weighed 115 pounds on 01/06/14 which flagged for a significant weight loss of 7.5% (12.5 pounds or 9.8%) in 30 days and for a significant weight loss of 10% (13.5 pounds or 10.4%) in 180 days. A 01/30/14 physician order began the provision of house supplement to Resident #6 twice daily. On 02/15/14 "Alteration in nutrition status; resident has had a gradual weight loss and history of significant weight loss" was identified as a problem on the resident's care plan. Interventions to this problem included snacks between meals as ordered and provision of altered consistency meals/snacks.	F 325	Resident discharged to the hospital on 4/8/14. 2. Dietary staff received in-service education on 4/4/14 by the Food Service Director to assure they understood the importance of providing residents with all the items specified on the meal card for each meal. In-service education provided to nursing staff on 4/11 and 4/24/14 to stress the importance of checking tray cards at the time of meal service to assure all items have been included on the resident□s tray and to contact the kitchen staff to provide any missing items. 3. Licensed nurses will be present in each dining room while meals are being served to monitor meal service to assure residents are receiving necessary items on their meal tray. All nursing staff will assist with meal service. Licensed Nurses will complete a nurse□s note to address weight variance. UM/DN to monitor the NN weekly along with documentation of meal consumption and supplements. 4. DNS will review all weights within 24 hours of entry into PCC to identify any 5 pound weight variances. Weight variances on the PCC Clinical Dash Board will be reviewed in clinical stand up to ensure that the RD has assessed/reassessed, care plan in place and updated as needed, Kardex updated for nursing assistants. Weight variances will continue to be reviewed at the monthly QAPI meeting and variances discussed to assure appropriate interventions are in place.	

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The resident's 03/11/14 Quarterly MDS documented his short and long term memory was impaired, his decision making skills were significantly impaired, he was 5'4" and weighed 115 pounds, he required assistance from staff with meal set-up only, and he had experienced no significant weight loss in the last 30 or 180 days.

A 03/11/14 Medical Nutrition Therapy Assessment, completed by the RD, documented Resident #6 was receiving a puree diet with large portions, ice cream with lunch and supper, and scheduled snacks twice daily. The RD documented, "BMI (body mass index) of 19.7 indicates normal weight status. Trend of weight loss over past 6 months noted. Resident had significant weight loss of 10% in 180 days. Resident was receiving house supplement BID (twice daily), d/c'd (discontinued) on 02/24/14 due to meal intake meeting needs. Resident consumes 75 - 100% of most meals, meeting greater than 100% of needs. Resident requires extensive assistance with ADLs (activities of daily living) but will not allow assistance with feedings. Resident receives sippy cup as adaptive equipment...."

The resident's Weight Summary documented he weighed 110 pounds on 03/18/14 which flagged for a significant weight loss of 10% (17.5 pounds or 13.7%) in 180 days and weighed 108 pounds on 04/01/14 which flagged for a significant weight loss of 10% (19.5 pounds or 15.3%) in 180 days.

At 12:52 PM on 04/02/14 Resident #6 was eating lunch in the day room. There was no ice cream on his lunch tray. Examination of his tray slip revealed that ice cream was identified as a meal

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preference at lunch and supper.

At 1:01 PM on 04/03/14 Resident #6 was eating lunch in the day room. There was no ice cream on his lunch tray. Examination of his tray slip revealed that ice cream was identified as a meal preference at lunch and supper.

At 12:46 PM on 04/04/14 Resident #6 was eating lunch in the day room. There was no ice cream on his lunch tray. Examination of his tray slip revealed that ice cream was identified as a meal preference at lunch and supper.

At 1:14 PM on 04/04/14 the dietary manager (DM) stated when a food was listed as a meal preference on resident tray slips, dietary placed that food on the resident trays during operation of the trayline. Therefore, he reported Resident #6 was supposed to have ice cream on his lunch and supper trays. The DM commented during operation of the trayline a dietary employee was designated to compare tray slips against meal trays to check for accuracy. He was unable to explain why Resident #6 did not receive his ice cream during the three lunch meals which were observed.

At 1:17 PM on 04/04/14 the cook asked the DM if the facility had ice cream available to place on resident trays. At this time the DM replied that he had observed ice cream placed on the trays of residents other than Resident #6 so the resident in question should also be receiving it.

At 2:32 PM on 04/04/14 nursing assistant (NA) #1 stated he did not recall Resident #6 getting ice cream at lunch on a regular basis.

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	345126	A. BUILDING _____ B. WING _____	C 04/04/2014

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F 325	Continued From page 12	F 325		

At 2:47 PM on 04/04/14 the RD stated she worked full time in the facility, and was available daily to complete nutrition assessments and make supplement recommendations. She reported that she could run resident weight records daily, but had not been alerted that Resident #6 experienced more weight loss since her 03/11/14 nutrition assessment of him. After being informed, the RD commented she might consider additional supplements for the resident in a follow-up assessment. Since Resident #6 was continuing to lose weight she explained it would be important for him to received foods that he or staff had identified as meal preferences. According to the RD, she discontinued Resident #6's BID house supplement on 02/24/14 because his meal intake was meeting his caloric and protein needs.

At 3:12 PM on 04/04/14 NA #2, who frequently assisted residents in the day room during the lunch meal, stated she knew Resident #6 liked ice cream, and usually ate 100% of it when he received it. However, she reported she did not think the resident received ice cream daily on his lunch tray.

At 3:20 PM on 04/04/14 Nurse #4 stated she had seen ice cream on Resident #6's lunch tray before, but the resident did not receive it on a daily basis.

At 4:13 PM on 04/04/14 the unit supervisor stated it was probably not a good idea to discontinue nutrition supplements for residents with a history of significant weight loss unless they had begun to gain considerable amounts of weight. She also reported it was especially important in residents with a history of weight loss to honor any food

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F 325	Continued From page 13 preferences they might express. At 4:52 PM on 04/04/14 the director of nursing (DON) stated it was important to honor resident food preferences, especially for those residents who were losing weight.	F 325		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to fix a drainage problem at the three-compartment sink which resulted in the overflow of water onto the kitchen floor and the accumulation of dried particles under the sink system. Findings included: A invoice billing the facility for work completed on 03/11/14 documented tile around the drain under the three-compartment sink was removed, an iron drain pipe was replaced, and the floor was patched and regrouted. At 9:57 AM on 04/03/14 the floor around the three-compartment sink was very wet. The aide operating the sink stated repairs were made on	F 371	F-371 1. There were no specific residents identified as having been affected by the stated deficient practices but such practices had the potential to affect all residents. a. Facility obtained 2 bids from qualified contractors to replace the defective grease trap located under the three-compartment sink in the kitchen by the conclusion of the revisit on 4/4/14. b. Facility received approval for an emergency capital expense in the amount of $4,650 to remove the old grease trap and install a new 100 pound grease trap	4/29/14

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F 371	Continued From page 14 the drainage system under the sink. She reported drainage was now better, but she was not sure it was fixed. At 10:00 AM on 04/03/14 the dietary aide began to drain the sanitizing and rinse sinks in the three-compartment sink system, and water rose above a grease trap under the sink, flooding the floor with water which included food particles. At 5:18 PM on 04/03/14 the maintenance manager (MM) stated on 03/11/14 repairs were completed on the three-compartment sink drainage system, but obviously the problem of flooding the kitchen floor with water and food debris was still not fixed. He reported he was in the process of getting bids to re-examine and fix this drainage issue. According to the MM, one company who was bidding for the repairs stated the grease trap below the sink was not large enough to handle the volume of water and solutions being released from what was now a three-compartment sink system. At 10:12 AM on 04/04/14 the cover was off the grease trap below the three-compartment sink system. Within a couple of minutes water and solutions released from the rinse and sanitizing sinks had risen above the grease trap, and began to run out onto the kitchen floor. At this time the dietary manager (DM) stated the 20-gallon capacity grease trap currently in use below the sink system was going to have to be replaced with a trap having a 40 - 50 gallon capacity. He reported he was monitoring the three-compartment sink system weekly, but had warned dietary employees that they needed to maneuver the throttle handle (which had been glued in place) carefully when emptying the sinks	F 371	that has a 50 GPM flow rate to accommodate the drainage from the three-compartment sink. c. Work to replace the defective grease trap is to start by 4/24/14 with a completion date of 4/26/14. 2. The stated deficient practice had the potential to affect all residents of the facility. a. Facility obtained 2 bids from qualified contractors to replace the defective grease trap located under the three-compartment sink in the kitchen by the conclusion of the revisit on 4/4/14. b. Facility received approval for an emergency capital expense in the amount of $4,650 to remove the old grease trap and install a new 100 pound grease trap that has a 50 GPM flow rate to accommodate the drainage from the three-compartment sink. c. Work to replace the defective grease trap is to start by 4/24/14 with a completion date of 4/26/14. 3. Once the new grease trap is installed we will fill the three-compartment sink to capacity and release the water from all three compartments simultaneously to assure that the new device is able to accept the maximum possible flow from the draining sinks. 4. Food Service Director will monitor the three-compartment sink on a daily basis Mon-Fri and immediately report any overflow problems to the Maintenance Supervisor and Administrator. Administrator will inspect the operation of	

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F 371	Continued From page 15 to prevent overflow. The DM commented he educated his staff not to empty multiple sinks in the sink system at the same time. At 11:50 AM on 04/04/14 the administrator stated the work to fix drainage associated with the three-compartment sink system would not be able to be completed until at least next week. He stated the DM was monitoring the sink drainage system for overflow weekly, and he was monitoring the same on a monthly basis. According to the administrator, the DM had only made him aware of problems with the drainage one time when a dietary employee was trying to empty all three sinks at one time. The administrator commented he did not observe any drainage problems when he conducted his 03/31/14 audit.	F 371	the sink on a weekly basis and findings will be reviewed by the facility QAPI Committee monthly for 3 months.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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	F 441		4/29/14

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F 441	Continued From page 16 (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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to disinfect a glucometer with a germicidal agent effective against blood bourne pathogens prior to use for 1 of 3 (Resident #28) residents observed for blood sugar monitoring. Findings included: Medical record review revealed Resident #28 was admitted to the facility on 05/05/03 with cumulative diagnoses of diabetes mellitus (DM) and cerebrovascular accident (CVA). In an observation on 04/02/14 at 12:00 PM Nurse #1 escorted Resident #28 to the bedside and provided privacy. Nurse #1 proceeded to wipe the glucometer with an alcohol wipe. Alcohol is not an Environmental Protection Agency registered	F 441	F 441 1. Resident #28 has had the glucometer cleaned with the appropriate germicide prior to and after use 2. Resident□s orders were reviewed to identify residents that require the use glucometer for finger stick blood sugar. 3. Nurse # 1 was reeducated on proper cleansing of glucometer on 4/6/14 by the DNS. Licensed nurses were reeducation on proper cleansing of glucometer on 4/11 and 4/24/14 by the SDC. Four licensed nurses will be observed across all three shifts by the Staff Development Coordinator weekly for 3 months to ensure proper cleansing of glucometer	

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F 441	Continued From page 17 disinfectant. At this point the Nurse was stopped and interviewed. In an interview on 04/02/14 at 12:03 PM Nurse #1 stated she should not have used alcohol to disinfect the glucometer. She indicated she should have used the disinfectant wipes provided by the facility to cleanse and disinfect the glucometer prior to using it. Nurse #1 stated this was the first blood sugar she had attempted this shift had not disinfected the glucometer at the beginning of the shift. In an interview on 04/03/14 at 1:00 PM Nurse #2 stated the germicidal wipes provided by the facility should always be used to clean and disinfect the glucometers prior to and after each use. She indicated alcohol was not a proper disinfectant for use on glucometers. In an interview on 04/04/14 at 1:06 PM Nurse #3 stated glucometers should be cleaned before and after each use with a special wipe provided by the facility. In an interview on 04/04/14 at 4:50 PM the Director of Nurses (DON) stated glucometers should be wiped with a germicidal wipe before and after use. She indicated alcohol should not be used. She stated she expected the nurses to use the wipes provided by the facility for the purpose of cleaning and disinfecting the glucometers and not to use alcohol wipes.	F 441	4. The results of the licensed nurses observation will be report the QAPI meeting monthly times 3 months.	