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	345407	A. BUILDING _____ B. WING _____	06/12/2014

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CROSS CREEK HEALTH CARE	1719 SWAN QUARTER ROAD SWANQUARTER, NC 27885

(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 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 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 physician interview, staff interview, and record review the facility failed, in a timely manner, to change treatments and put nutrition interventions in place to promote healing following a decline in a pressure ulcer/emergence of new pressure ulcers for 1 of 2 sampled residents (Resident #62) who had pressure ulcers during their nursing home stay. Findings included: Resident #62 was admitted to the facility on 04/10/14, readmitted on 04/22/14, and discharged from the facility on 06/5/14. The resident's documented diagnoses included pressure ulcers of the ankle and buttocks, history of fall and fracture (broken right ankle with repair and left tibial/fibular fracture), diabetes, and obesity. A 04/11/14 Admission Nursing Review documented the resident was admitted to the facility without the presence of pressure ulcers. A 04/15/14 Weekly Pressure Ulcer Review documented when a left knee brace was	F 314	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 314 SS= D Corrective Action for Resident Affected Resident # 62 was discharged on 6/5/14. Corrective Action for Resident Potentially Affected All residents with pressure ulcers have the potential to be affected by this alleged deficient practice. Wound Assessment	7/11/14

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

Electronically Signed | 06/30/2014

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F 314	Continued From page 1 removed the resident had a 2 x 2 x .01 centimeter (cm) stage II pressure ulcer on her posterior left ankle. The wound bed was 100% granulation tissue with no exudate and no odor. A 04/15/14 physician order instructed staff to clean Resident #62's left ankle ulcer with betasept, apply bactroban, apply 4 x 4, and wrap in gauze daily. The resident's 04/17/14 admission minimum data set (MDS) documented her cognition was moderately impaired, she required extensive assistance or was totally dependent on staff for all of her activities of daily living (ADLs) except eating, she was occasionally incontinent of urine/ always incontinent of bowel, she was at risk for developing pressure ulcers, and she had one stage II pressure ulcer with a granulation tissue wound bed. Record review revealed the resident was hospitalized between 04/20/14 and 04/22/14. 04/20/14 hospital labs documented the resident's albumin level was 2.4 grams per deciliter (g/dL) with the normal range being 3.4 - 5.0 g/dL, but her total protein was within normal limits. A 04/22/14 Readmission Nursing Review documented Resident #62's left ankle ulcer remained a stage II, measuring 2 x 2 x .02 cm. A 04/24/14 Dietitian Nutritional Assessment documented the resident was on a low concentrated sweets (LCS), no-added salt (NAS), no fried food diet, and was receiving low fat milk with meals and a diabetic snack at night. The assessment also documented the resident's meal	F 314	Nurses attended wound management training provided by Medline on 6/5/14. The training included: 1) Anatomy and Physiology of Skin, Normal Wound Healing 2) Factors Affecting Wound Closure 3) Prevention-Treatment to Keep Skin Healthy 4) Skin and Wound Assessment 5) Wound Bed Preparation 6) Topical Treatment and Interventions (See Attachment #1) Systemic Changes Training of Policy provided by the Quality Assurance Consultant on 5/6/14 Was reviewed with all nurses 6/27/14-7/3/14 (See Attachment #2 and #12) This information has been integrated into the standard orientation training for nurses involved in wound assessments. Recommendations by the Consultant Dietician will be reviewed with the Attending Physician upon completion. (See Attachment #3) The Dietary Consultant Report will be reviewed in the weekly QA Committee Meeting to ensure all recommendations have been addressed. (See attachment #4 pages 1-3) Quality Assurance The Director of Nursing or Designee will monitor this issue using the Weekly wound report in the Point Click Care Web based Documentation System The monitoring will include verifying that	

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F 314	Continued From page 2 consumption was 50 - 75%, the resident was experiencing problems with nausea and vomiting, and the resident had a stage II pressure ulcer. No new nutritional recommendations were made A 04/29/14 Weekly Pressure Ulcer Review documented Resident #62 developed stage II pressure ulcers to her bilateral buttocks. A 05/04/14 5:55 PM progress note documented, "Left ankle wound redressed. No changes in healing process. Minimal sanguineous drainage noted." A 05/05/14 care plan documented, "I have pressure ulcers and potential for further pressure ulcer development secondary to immobility, bowel/bladder incontinence" was a problem for Resident #62. Interventions to this problem included, "Assess/record/monitor wound healing each week. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD. Monitor nutritional status. Serve diet as ordered, monitor intake and record." A 05/06/14 Weekly Pressure Ulcer Review documented the resident's stage II left ankle pressure ulcer measured 2 x 2 x .01 cm, but the wound bed was 75% eschar. A 05/12/14 6:18 PM progress noted documented, "Necrotic tissue noted covering the wound (left ankle pressure ulcer). To be seen on rounds by ___ (name of Resident #62's primary physician). A 05/13/14 Weekly Pressure Ulcer Review	F 314	changes in wounds were reported to MD and addressed timely. (See attachment #5 pages 1-2) The Director of Nursing or designee will monitor Nutritional Interventions by reviewing the Dietary Consultant Report to verify accurate and timely completion (See Attachment #4 Pages 1-3). Results will be reported weekly to the QOL/QA committee and corrective action initiated as appropriate. This will be done weekly for three months or until resolved by QOL/QA committee. (See Attachment #6) The QOL/QA committee is the main quality assurance committee. This regularly scheduled weekly meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, and Dietary Manager. The Medical Director will review during the Quarterly QA Meeting.	

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documented the resident's unstageable left posterior ankle ulcer measured 2 x 2 x 0.1 cm, and the wound bed was necrotic. "To be seen on rounds tomorrow for further evaluation." It was also documented the resident had a new pressure ulcer to the lower left buttock (stage II measuring 0.5 x 0.5 cm).

There was no physician encounter note for Resident #62 dated 05/14/14, and there were no electronic progress notes mentioning that the resident was seen on rounds on 05/14/14. However, progress notes did indicate that a planned discharge for the resident on 05/14/14 did not occur.

The resident's May 2014 treatment administration record (TAR) documents all ulcers on the buttocks were healed on 05/18/14.

A 05/19/14 6:56 PM progress note documented, "Wound (left ankle pressure ulcer) noted with minimal drainage on old drsg (dressing), slight odor noted. Area surrounding wound noted intact with some necrotic tissue noted."

In a 05/20/14 1:01 PM dietary progress note the facility's registered dietitian documented, "5 lb (pound) wt (weight) loss since readmission. Has multiple wounds. Intake (at meals) less than 50% and at times refuses. Albumin low but BUN (blood urea nitrogen) elevated. Recommend vitamin C 500 mg (milligrams) BID (twice daily) for wound healing and 206 juice for protein/calories.

A 05/20/14 Weekly Pressure Ulcer Review documented the resident's left posterior ankle ulcer measured 2.4 x 1.5 x 0.1 cm, the wound

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bed was 80% eschar and 20% epithelial tissue, and there was light serous exudate. "Blackened area beginning to separate some from the edges leaving blackened area just mid wound. Wound edges beginning to epithelialize."

A 05/28/14 MD (physician) Encounter note documented, "Check left posterior ankle wound--stage III, necrotic tissue."

A 05/28/14 physician order documented the ankle ulcer was to be cleaned with betasept, Bactroban/Santyl was to be applied, the wound was to be covered with 4 x 4's, and wrapped in gauze daily.

Record review revealed it took from 05/6/14 until 05/28/14 to change the pressure ulcer treatment for a wound that developed a necrotic wound bed, and introduce the use of an enzymatic agent.

It was not until 05/30/14 that a physician order was written to implement the RD's recommendation for 206 juice and vitamin C 500 mg BID.

Record review revealed it took from 04/29/14 until 05/30/14 for new nutrition interventions to be put in place to promote wound healing.

A 06/03/14 Weekly Pressure Ulcer Review documented the left ankle ulcer measured 2.5 x 1 x 0.2 cm, the wound bed was 50% slough and 50% granulation tissue, and there was light serous exudate. "No black tissue remains in the center. Chemical debridement successful. Continue as ordered to remove more slough."

At 10:42 AM on 06/11/14 Resident #62's primary

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physician stated he completed rounds twice a month in the facility, but would expect to be kept up to date on pressure ulcer progress, including improvement and decline, between his on-site visits. He reported the facility needed to notify him if a shallow stage II pressure ulcer developed eschar in the wound bed. According to the physician, he frequently used an enzymatic agent to help rid wounds of necrotic tissue and accelerate their healing process.

At 2:18 PM on 06/11/14 the director of nursing (DON) stated the facility was supposed to keep Resident #62's physician updated by phone about changes in wounds between his facility rounds. She reported when residents had eschar in their wound beds the goal was to remove necrotic tissue and get to the healthy tissue to promote healing. The DON commented she did not think Resident #62 was seen by her physician who rounded on 05/14/14 because she was tentatively scheduled for discharge that day. She explained the resident's name was probably not added to or was removed from the list of residents to be seen on 05/14/14.

At 4:05 PM on 06/11/14 the DON stated the registered dietitian (RD) was in the building once a month, but she expected the dietary manager (DM) to keep the RD informed via phone about changes in pressure ulcers, such as decline in ulcers or development of new ulcers, so the RD could make nutrition recommendations to promote wound healing. After reviewing Resident #62's medical record, the DON reported she saw no documentation of RD involvement between her 04/24/14 assessment and the RD's 05/20/14 recommendation for vitamin C and fortified juice (during this time period the resident developed

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F 314	Continued From page 6 three new ulcers to the buttocks and experienced a decline in the left ankle ulcer). The DON explained the delay between the 05/20/14 RD recommendation and it being put into place via physician order on 05/30/14 was caused by the physician's preference to approve RD recommendations during his rounds in the facility. According to the DON, the facility could call the physician for orders to carry out recommendations between visits in emergency situations.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		7/11/14

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F 329	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, physician interview, pharmacy interview, family interview, staff interview, and record review the facility started a resident (Resident #52) on a scheduled dose of antipsychotic medication that exceeded the maximum geriatric dosing recommendation outlined in the State Operations Manual (SOM) for 1 of 5 residents reviewed for unnecessary medications. Findings included: The State Operations Manual (SOM) documented in the daily dose threshold table for antipsychotic medications used to manage behavioral symptoms relating to dementing illnesses in the elderly that the recommended maximum geriatric dose of Haldol was two milligrams (mg) daily. Resident #52 was admitted to the facility on 06/07/13 and readmitted 02/11/14. The resident's documented diagnoses included anxiety, depression, Alzheimer's dementia, explosive personality disorder (from a physician order for a diagnosis of aggressive behavior), psychosis (from a physician order for a diagnosis of confusion), and chronic pain. Record review revealed the resident was admitted to the facility on as needed (PRN) Xanax (anxiolytic) one mg three times daily (TID) as needed. However, the resident was not receiving an antipsychotic medication. A 07/23/13 physician order provided Resident #52 with an one-time intramuscular (IM) dose of	F 329	F 329 SS= D Corrective Action for Resident Affected: A dose reduction was ordered by the Primary Care Physician for resident #52 on 6/14/14. Corrective Action for Resident Potentially Affected: All residents receiving antipsychotic medications have the potential to be affected. The medical records for all residents receiving antipsychotics medications were reviewed by the consultant pharmacist on 6/2/14 and 6/4/14 for the potential for gradual dose reductions and /or risk versus benefit statements. No new antipsychotics have been ordered since the pharmacist review. Recommendations were sent to the Primary Care Physician as indicated by the review. (See attachment #11 page 1-2)) Systemic Changes: The Attending Physician was provided with a copy of The daily dose threshold table for antipsychotic medications used to manage behavioral symptoms relating to dementing illnesses in the elderly from the State Operations Manual (SOM) for educational purposes. (See Attachment #9 pages 1-6) The Consultant Pharmacist will continue to maintain a spreadsheet for all residents	

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F 329	Continued From page 8 Geodon (antipsychotic medication) 10 mg. A 08/14/13 physician order changed the resident's Xanax regimen, initiating PRN Xanax 0.5 mg every eight hours and Xanax 0.5 mg TID. Progress notes documented the resident was becoming very anxious, demanding to go home and attempting to exit the building. Progress notes documented that PRN Xanax was minimally effective, virtually not effective unless the resident was already exhausted. A 08/29/13 physician order started Resident #52 on PRN Haldol (antipsychotic medication) 1 mg TID for control of behaviors. Review of the resident's medication administration records (MARs) documented she received six 1 mg doses of Haldol in September 2013, nine 1 mg doses of Haldol in October 2013, two 1 mg doses of Haldol in November 2013, and one 1 mg dose of Haldol in December 2013 before the medication was discontinued by a 12/07/13 physician order. The resident did not receive more than one dose of Haldol on any of the days the medication was administered. The resident's 02/17/14 quarterly minimum data set (MDS) documented her cognition was moderately impaired, she was experiencing little interest in doing things/depression/lack of energy/poor appetite, but was experiencing no hallucinations, no delusions, no behaviors, no resistance of care, and no wandering. A 03/23/14 progress note documented Resident #52 was experiencing increased behaviors, obtained scissors to cut off her Wanderguard, tried to hit staff with her cane, and threatened to	F 329	receiving antipsychotic medications that will include: 1) Resident Name and location 2) Diagnosis related to Antipsychotic medication 3) Date started 4) Dates of gradual dose reductions (GDR) or risk versus benefit statement (RVB), or dosing above the (SOM) recommended thresholds (DOT) The Director of Nursing and the Administrator will be provided with an updated copy of the spread sheet monthly. (See attachment #10) Quality Assurance: The Director of Nursing and/or the Administrator will monitor this issue using the "Antipsychotic Medication Spreadsheet The monitoring will include verifying that all resident receiving antipsychotic medications medical record has been reviewed and recommendations have been made to the Primary Care Physician for dose reductions or risk versus benefit statements, or dosing in excess of (SOM) recommended thresholds for further action as needed. This will be done monthly for three months or until resolved by QOL/QA committee. Reports will be given to the Monthly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. This regularly scheduled monthly meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, and Dietary	

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F 329	Continued From page 9 call the sheriff's office. A 03/23/14 physician order provided Resident #52 with an one-time IM dose of Haldol 2 mg, and initiated PRN Haldol every six hours, Haldol 1 mg TID, and requested urine be obtained for an urinalysis (UA). 3/26/14 lab results documented the resident's UA was negative for an urinary tract infection (UTI). A 03/26/14 physician order added agitation, confusion, and aggressive behavior to Resident #52's diagnoses list. A 04/05/14 Note to Attending Physician/Prescriber, completed by the facility's consultant pharmacist, documented, "On 03/23/14 several med changes were made in regards to psych(iatric) meds. Haldol 1 mg Q (every) 8 hours scheduled was started, Trazadone increased to 50 mg BID (twice daily) and Xanax 0.5 mg Q 6 - 8 hrs prn was added. Resident was already taking Xanax, to be dc'd (discontinued) when other meds added/changed?" On 04/9/14 Resident #52's primary physician replied,"Unfortunately it has taken high doses of psychotropics to control this patient--no change recommended at this time." "I receive antipsychotic medication Haldol PRN related to dx (diagnosis) of dementia with behaviors with risk for adverse side effects" was identified as a problem in the resident's 06/15/14 care plan. Interventions to this problem included, "administer medication as ordered by MD. insure that pharmacist consultant reviews my meds	F 329	Manager. The Medical Director will review during the Quarterly QA Meeting	

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F 329	Continued From page 10 monthly and prn. MH (mental health) consult prn. report any of the following to nurse immediately if noted: involuntary movements, nausea/vomiting, palpitations, chest pain, change in balance and coordination, muscle rigidity, restlessness, etc. report sedation or change in mental functioning to nurse if noted." Review of Resident #52's June 2014 MAR revealed she was still receiving scheduled Haldol 1 mg TID. At 3:18 PM on 06/10/14 Resident #52 stated she was sleepy, and in conversation the resident seemed to have a flat affect. At 4:37 PM on 06/10/14 nursing assistant (NA) #1 stated she was not aware of Resident #52 having any behaviors now or in the past. She commented the resident was a very sweet lady. At 10:37 AM on 06/11/14 Nurse #2 stated Resident #52 experienced frustration and anxiety related to wanting to go home, would call family to take her home, and at times demanded staff to let her go home. However, she reported the resident did not exhibit verbal or physical abuse or yell out. She commented the resident had no hallucinations, but was confused. For example, she explained the resident would write letters to her mother and father and ask for the staff to mail them. At 10:42 AM on 06/11/14 Resident #52's primary physician stated if he had to resort to putting residents on antipsychotic medication he frequently started with Haldol or Geodon, especially Geodon. He reported he tried not to use antipsychotics unless residents were severely	F 329		

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psychotic, agitated to the point they could hurt themselves or others, were very physically aggressive, or were in severe emotional distress. The physician commented he had treated Resident #52 for 10 + years. According to the physician, when the resident was at home she had a history of repeat calls to the sheriff and her family reporting she heard noises, someone was trying to break in, etc. He explained the resident seemed to be seeking attention. He stated it took a load of medicine to manage the resident's behaviors. The physician reported he thought an antipsychotic agent may have been used in the past for resident, but he was not sure which agent was used, the dosage, or for how long the medication was taken.

At 1:46 PM on 06/11/14 NA #2 stated Resident #52 became anxious occasionally, but was not verbally or physically abusive and did not yell out. She reported the resident occasionally wanted to go home or sought exit from the facility. She commented that all these behaviors occurred much less frequently now than when the resident was first admitted.

At 2:18 PM on 06/11/14 the director of nursing (DON) stated she thought Resident #52's physician started her on such a high dose of regularly scheduled Haldol because he was familiar with the resident's behaviors prior to her nursing home admission.

At 3:08 PM on 06/11/14 a family member (Nurse #3) stated Resident #52 had taken a lot of Xanax before being admitted to the nursing home, but to her knowledge the resident was never on an antipsychotic medication. She reported the resident told her that she was more sleepy than

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F 329	Continued From page 12 usual in the last two or three months. At 4:56 PM on 06/11/14, during a telephone interview, the facility's consultant pharmacist stated Haldol was not a first line of choice for antipsychotic use in the elderly. She reported she would only expect Haldol to be used when residents had a true psychiatric diagnosis. In general she commented antipsychotic medications were used to control violent/emotional outbursts, physical aggression, and danger to residents or those around the residents. The pharmacist stated Haldol 1 mg TID was a little high for dosing the geriatric population.	F 329		
F 441 SS=F	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 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441		7/11/14

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F 441	Continued From page 13 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 observations, record review and staff interviews, the facility failed to follow the manufacturer ' s recommendations for disinfecting 2 of 2 blood glucose meters (glucometers) observed being used during medication administration observation. The facility also did not have a system in place for identification of the resident dedicated blood glucose meters (glucometers) for 2 of 2 residents (Resident #1 and #37) who were observed receiving finger stick blood glucose testing. Findings included: The facility's policy entitled "Glucometers", dated 01/01/2011, indicated that the policy of the facility was to utilize individual glucometers for each resident to minimize the risk of in house acquired infections related to the use of glucometers. It was noted that the glucometer would be disinfected per the manufacturer's	F 441	F 441 SS= F Corrective Action for Resident Affected No specific resident is identified. Corrective Action for Resident Potentially Affected All residents receiving finger stick blood sugars have potential to be effected. All existing sanitation wipes were removed from use on 6/16/14. All residents receiving finger stick blood sugars have an individual glucometer and case each of which are labeled. Systemic Changes New sanitation wipes with the EPA Registration Number: 67619-12 were purchased on 6/25/14 (See attachment #7 pages 1-4) Nurses and Medication Aides	

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F 441	Continued From page 14 recommendations and placed back into facility storage upon the resident's discharge from the facility. It was also noted that any time the glucometer became visibly soiled it was to be cleaned and disinfected according to manufacturer ' s guidelines. The [brand name] cleaning and disinfecting guidelines for the [brand name] glucometer, dated 11/30/2012, noted to disinfect the meter surface with [a brand name] hospital cleaner disinfectant towel with bleach. It was noted that other wipes with the Environmental Protection Agency (EPA) registration number of 56392-8 could also be used. The disinfecting guideline for the meter documented to wipe all external areas of the meter including both the front and back surfaces until visibly clean. It further documented to avoid using alcohol or ammonia to clean the meter. The cleaning guideline for the meter surface noted to use a moist lint free cloth dampened with a mild detergent. It was also noted in these guidelines that per the Center for Disease Control (CDC), shared blood glucose meters should be cleaned and disinfected after every use. There was no mention of how to clean and disinfect resident dedicated glucometers in these guidelines. 1. During a medication administration observation on 06/10/14 at 4:10 PM, Nurse #1 opened the bottom drawer of the medication cart to retrieve a glucometer. She pulled out 3 empty black cases. She then opened the top left drawer of the medication cart. Nurse #1 commented that there were 3 unlabeled glucometers in the drawer but 2 of them needed batteries. She picked up the third meter and stated that meter must belong to Resident #1. When questioned about	F 441	were in-serviced on the storage, labeling, and cleaning of glucometers on 6/27/14-7/03/14 (See Attachment #12 page 1-3) Each glucometer and storage case currently in use is labeled with the individual resident□s name. Quality Assurance The Director of Nursing or Designee will monitor this issue during rounds and general observation. The monitoring will include verifying that correct sanitation wipes are being used. And that each resident requiring finger sticks has an individual glucometer and case both labeled with the resident name. (See attachment #8 pages 1-2) This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. This regularly scheduled weekly meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, and Dietary Manager. The Medical Director will review during the Quarterly QA Meeting.	

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F 441	Continued From page 15	F 441		

cleaning/disinfecting the meters, she responded that third shift staff disinfected all of the meters on third shift. Nurse #1 also stated that since this was a dedicated meter it didn ' t need to be cleaned after each use since it was used for a specific resident. Nurse #1 gathered supplies which consisted of an alcohol pad and a blood glucose testing strip and went into Resident #1's room to perform a finger stick. Nurse #1 did not clean the meter after completion of the finger stick and placed it back into one of the black cases. There was no visible name label noted on the black case. Nurse #1 reported that a [brand name] hard surface disinfecting wipe was used to clean the glucometers.

Upon observation of the [brand name] disinfecting wipe container, on 06/10/14 at 4:30 PM, it was noted that the product contained ammonium chloride 0.14%. The EPA registration number noted on the container was 1839-190-5741. According to the instructions for cleaning the meter noted on the [brand name] hard surface disinfecting wipe container, one wipe was used to clean the surface of the meter. It was noted that when disinfecting hard non-porous surfaces, the surface to be treated was to be thoroughly wet and was to remain visibly wet for 5 minutes. The surface was to be allowed to air dry.

During an interview with Nurse #2, on 06/11/14 at 9:30 AM, she stated each diabetic resident was assigned their own individual glucometer. She stated third shift staff were responsible for cleaning and disinfecting all of the glucometers. Nurse #2 stated there were 2 residents on her hall who had assigned meters and thought one of them was kept in the resident's room.

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F 441	Continued From page 16 During an interview with the Director of Nurses (DON), on 06/11/14 at 4:20 PM, she stated it was the facility's policy that diabetic residents have dedicated glucometers which were labeled with each resident's name. She commented that according to the policy the meters were kept in the resident's rooms but that had been changed. The DON stated the meters were not being kept in the rooms for safety reasons and were being stored in the medication carts on each hall. She stated it was the responsibility of the third shift nurses to clean and disinfect all of the meters every night. The DON reported each nurse should disinfect the dedicated machines at the beginning of their shift prior to the first use to ensure that the meter had been disinfected. She stated she also expected the nurses to clean the machines after each use even though it was a dedicated resident meter. The DON stated the extra meters should be disinfected before and after each use. She also reported that she had realized today that the cleaning solution they were using contained ammonium chloride and it also was not the cleaning solution recommended by the manufacturer. The DON stated the current method for using and storing the glucometers made it difficult for staff to know which meter belonged to which resident. She added that she had been made aware yesterday following medication administration observations that the black cases were not clearly labeled for each resident. The DON stated there were 7 diabetic residents who had dedicated glucometers. She also stated there were 2 extra glucometers for use on other residents who did not have a dedicated glucometer. She stated it would be difficult for staff to know which was a dedicated meter and which was extra if the meter itself wasn't labeled. The DON added that she hadn't	F 441		

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F 441	Continued From page 17 figured a way as yet to ensure identification of the meters but the residents' black glucometer cases were now clearly labeled. 2. During a medication administration observation for Resident #37, on 06/09/2014 at 4:20 PM, Nurse #4 obtained one of 3 glucometers (device used for measuring blood glucose levels) which was not labeled with the resident's name from the top drawer of the 100 hall medication cart. Nurse #3 used the [brand name] disinfecting wipe to clean all surfaces of the glucometer. She placed the glucometer on the top of the medication cart, fanned the glucometer with her hand for approximately 18 seconds to promote drying. After the glucometer was dry, Nurse #3 took the glucometer, a blood glucose testing strip, and an alcohol pad into Resident #37's room and used the glucometer to check the resident's blood glucose. In an interview conducted with Nurse #4 on 06/09/2014 at 4:20 PM during the medication administration observation, Nurse #4 stated that each diabetic resident used to have a glucometer dedicated his/her own use, but added that this was no longer the case. She explained that there were 2 functioning glucometers for the hall on which the resident was residing, and that the glucometers were disinfected with the [brand name] disinfecting wipes before and after each use. She stated that the third glucometer in the drawer was no longer in use because she thought it needed batteries. When questioned whether there were containers for storing the glucometers, she stated there were zippered cases for storage. She opened the bottom left drawer of the	F 441		

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F 441	Continued From page 18 medication cart to reveal three black zippered cases, none of which were labeled with resident names. Upon observation of the [brand name] disinfecting wipe container, on 06/10/14 at 4:30 PM, it was noted that the product contained ammonium chloride 0.14%. The EPA registration number noted on the container was 1839-190-5741. According to the instructions for cleaning the meter noted on the [brand name] hard surface disinfecting wipe container, one wipe was used to clean the surface of the meter. It was noted that when disinfecting hard non-porous surfaces, the surface to be treated was to be thoroughly wet and was to remain visibly wet for 5 minutes. During an interview with the Director of Nurses (DON), on 06/11/14 at 4:20 PM, she stated it was the facility's policy that diabetic residents have dedicated glucometers which were labeled with each resident's name. She commented that according to the policy the meters were kept in the resident's rooms but that had been changed. The DON stated the meters were not being kept in the rooms for safety reasons and were being stored in the medication carts on each hall. She stated it was the responsibility of the third shift nurses to clean and disinfect all of the meters every night. The DON reported each nurse should disinfect the dedicated machines at the beginning of their shift prior to the first use to ensure that the meter had been disinfected. She stated she also expected the nurses to clean the machines after each use even though it was a dedicated resident meter. The DON stated the extra meters should be disinfected before and after each use. She also reported that she had realized that day (06/11/2014) that the cleaning	F 441		

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F 441	Continued From page 19 solution they were using contained ammonium chloride and it also was not the cleaning solution recommended by the manufacturer. The DON stated the current method for using and storing the glucometers made it difficult for staff to know which meter belonged to which resident. She added that she had been made aware yesterday following medication administration observations. that the black cases were not clearly labeled for each resident. The DON stated there were 7 diabetic residents who had dedicated glucometers. She also stated there were 2 extra glucometers for use on other residents who did not have a dedicated glucometer. She stated it would be difficult for staff to know which glucometer was a dedicated meter and which was an extra one if the meter itself was not labeled. The DON added that she hadn't figured a way as of yet to ensure identification of the meters but that the residents' black glucometer cases were now clearly labeled.	F 441		