STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 04/12/2017

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LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, pharmacy review and staff interviews, the facility failed to make sure the reconstituted antibiotic medication was completely removed from the glass vial into the intravenous bag for one of one residents being treated for a urinary tract infection with intravenous antibiotic medication (Resident #1). The findings included: Resident #1 was admitted to the facility 4/25/16. Cumulative diagnoses included, in part, vascular dementia and chronic/ colonized urinalysis. A Quarterly Minimum Data Set modification dated 2/1/17 indicated Resident #1 had short term and long term memory impairment and was severely impaired in cognition. Extensive assistance was needed with toilet use. The assessment indicted Resident #1 had an indwelling urinary catheter. There was no diagnosis of urinary tract infection during the assessment period. Medications included the use of antibiotics for 7 days during the assessment period. A care plan dated 11/2/16 and last revised on 2/16/17 stated Resident #1 had an indwelling catheter related to a sacral pressure ulcer and hematuria (blood in urine) noted following recent	F 281	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 date or dates indicated. F 281-483.21(b)(3)(i)SERVICES PROVIDED MEET PROFESSIONAL STANDARDS Facility failed make sure the reconstituted antibiotic medication was completely removed from the glass vial into the intravenous bag for one of one residents (Resident #1) being treated for a urinary tract infection with intravenous antibiotic medication Corrective Action for Resident Affected:	4/28/17

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

Electronically Signed | 04/27/2017

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F 281	Continued From page 1 hospitalization. Interventions included, in part, monitor. Record/ report to physician for signs and symptoms of urinary tract infection: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. A hospital discharge summary dated 3/27/17 included a discharge diagnosis of urinary tract infection secondary to escherichia coli and pseudomonas (bacteria). Discharge medications included cefepime (antibiotic) 2 grams intravenous (IV) every 12 hours until 4/4/17, then discontinue. A review of physician orders revealed a physician order dated 3/27/`7 for cefepime 2 grams IV every 12 hours until 4/3/17. A physician order dated 3/28/17 (revision) indicated to administer cefepime 2 grams IV every 12 hours until 4/4/17 . A physician order dated 3/29/17 revealed an order for cefepime 2 grams IV every 12 hours until 4/5/17. A review of the March and April Medication Record (MAR) revealed Resident #1 received cefepime 2 grams IV every 12 hours from 3/28/17 through 4/5/17. A grievance filed on behalf of Resident #1 dated 4/3/17 stated there was a concern that Resident #1 did not get all of his antibiotic on 4/3/17. The investigation completed by the facility stated there was approximately 10 milliliters of fluid in the	F 281	Physician was notified of the alleged practice and no new orders were given. The staff licensed nurse assigned to the resident was re-educated by the Director of Nursing by April 5, 2017 on the Intravenous (IV) Policy/Proper way to reconstitute intravenous (IV) antibiotic medication prior to administration. Corrective Action for Resident Potentially Affected: All residents have the potential to be affected by this practice. On 4 April 2017, the Director of Nursing implemented education on the Intravenous (IV) Administration Policy - on the importance of making sure that when reconstituting antibiotic medication that all solution is completely removed from the glass vial into the intravenous (IV) bag. The Director of Nursing instituted an addendum on 12 April 2017 that included the directions for activation and reconstitution of intravenous antibiotic. Systemic Changes On 24 April 2017, the Director of Nursing in-serviced all registered nurses and licensed practical nurses the full time, part time and as needed (PRN) licensed nurses. Topics included: the Intravenous (IV) Policy and Proper way to reconstitute Intravenous (IV) antibiotic medication prior to administration. The Director of Nursing will ensure that all licensed nurses who did receive training by April 28th, 2017 will	

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F 281	Continued From page 2 glass vial. On 4/11/17 at 10:50AM, an interview was conducted with the Director of Nursing. She stated a family member came to her on 4/3/17 and informed her that there was ½ bottle of antibiotic medication that had not been administered to Resident #1. The Director of Nursing stated she went to Resident #1 ' s room and observed approximately 10 milliliters of fluid in the glass vial that was attached to the plastic IV bag. The Director of Nursing explained she had not observed that much liquid in the glass bottle and was unsure if the medication had leaked back into the glass bottle from the plastic IV bag. On 4/11/17 at 11:00AM, an interview was conducted with Nurse #2. She stated she provided care for Resident #1 on 4/3/17 and observed the glass vial that contained the antibiotic medication. She explained the procedure for IV administration of the antibiotic medication. The glass medication bottle was attached to the IV fluid that contained 100milliliters of liquid. The medication came that way from the pharmacy. There was an applicator on the medication bottle and that would be pushed down to open up the IV fluid. The IV fluid from the bag was squeezed to fill the glass bottle with the medication in it ½ full. The bottle was shaken to dissolve the medication. Then the glass bottle was turned upside down and the IV bag was squeezed again to make the medication went back into the IV bag for administration. Nurse #2 stated there was usually a small amount (1-2 milliliters) that seeped back into the glass bottle with the most amount she had ever seen being 5 milliliters. Nurse #2 stated there was approximately 8-10 milliliters of liquid in the glass bottle and it was unusual to see that	F 281	not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance (QA) Process to verify that the change has been sustained. Quality Assurance The Director of Nursing, or the Minimum Data Set (MDS) Nurse, or Support Nurse will monitor this issue using the Quality Assurance (QA) Survey Tool. Observing that when an intravenous antibiotic order is implemented that the licensed nurses that will be administering the intravenous antibiotic can demonstrate the proper technique of reconstituting the antibiotic correctly and making sure that all solution is completely removed from the glass vial back into the intravenous bag. Any issues will be reported to the Administrator. License Nurses will perform peer review at the time of all intravenous antibiotics administration daily, each day of the week times four weeks then weekly times 2 months. In the event of no intravenous antibiotics orders during the next 90 days we will extend the audit until intravenous antibiotic administration can be reviewed by Quality Assurance (QA) Committee. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance (QA)	

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F 281	Continued From page 3 amount of liquid remaining in the glass bottle after administration. On 4/11/17 at 11:29AM, an interview was conducted with Resident #1 ' s physician. He stated he had ordered additional doses of IV antibiotic medication due to the concern that Resident #1 had not received all of the IV antibiotic medication on 4/3/17. He stated there was no way of knowing how much of the fluid was saline and how much was antibiotic. Resident #1 ' s physician said he felt it would not have made any difference if Resident #1 had missed one whole dose of IV antibiotic. On 4/12/17 at 8:20AM, an interview was conducted with Nurse #3 who was the nurse who hung the IV antibiotic medication on 4/3/17. She stated, to her knowledge, all of the antibiotic medication went into the IV bag. She stated sometimes there was a small amount that would leak back into the bottle and, if that happened, she re-inverted the glass bottle and squeezed the IV bag to get all of the medication out of the glass bottle. She stated she did not recall doing that for Resident #1 on 4/3/17. On 4/12/17 at 9:13AM, an interview was conducted with the pharmacist. She stated the IV antibiotic that was provided for Resident #1 came with the glass vial of antibiotic attached to the IV bag. To activate the antibiotic that was in the glass bottle, the nurse would puncture the vial, mix the medication and squeeze the IV bag to get the medication into the IV solution, There might be a very small amount remaining in the bottle-1-2 milliliters probably; if 8-10 milliliters was still in the glass bottle, the nurse probably did not get all the medication into the IV bag for infusion.	F 281	Meeting. The weekly Quality Assurance (QA) Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set (MDS) Coordinator, Support Nurse, Therapy Director or Rehabilitation Aide, Health Information Manager, Dietary Manager and the Administrator. Compliance date: April 28th, 2017	

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F 281	Continued From page 4 On 4/12/17 at 9:53AM, an interview was conducted with the Director of Nursing who stated she expected staff to make sure all of the medication had run from the glass bottle into the IV bag. She said they did observe the last dose of IV antibiotic given to Resident #1but did not document it anywhere and did not audit the resident who received IV medication through 4/10/17. She stated she did not obtain instructions from the pharmacy regarding mixing of IV antibiotics using the glass bottle and IV bag and did not utilize it when she in-serviced staff regarding making sure the IV antibiotic was reconstituted and had been transferred into the IV bag prior to administration.	F 281		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 441		4/28/17

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F 441	Continued From page 5 (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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the	F 441		

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F 441	Continued From page 6 spread of infection. (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 observation, staff interview, manufacturer ' s specifications and facility policy, the facility failed to follow manufacturer ' s specifications for effective use of germicidal wipes used for the disinfection of the glucometer between residents for one of two sampled residents (Resident #5). The findings included: The Centers for Disease Control and Prevention (CDC) Summary statement on Infection Prevention during Blood Glucose Monitoring and Insulin Administration reports, in part: " The Centers for Disease Control and Prevention (CDC) has become increasingly concerned about the risks for transmitting hepatitis B virus (HBV) and other infectious diseases during assisted blood glucose monitoring and insulin administration ...Whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer ' s instructions. " Recommendations for Cleaning and Disinfection of Glucometers North Carolina Statewide Program for Infection control and Epidemiology (SPICE) state, in part, "2. If no visible organic material is present, disinfect after each use the exterior surfaces following the manufacturer ' s directions using a cloth/wipe with either an EPA registered detergent/germicide with a tuberculocidal or HBV 9hepatitis B virus)/ HIV (human immunodeficiency virus) label claim, or a	F 441	F 441-483.80(a)(1)(2)(4)(e)(f)INFECTION CONTROL. PREVENT SPREAD, LINENS Facility failed to follow manufacturer's specifications for effective use of germicidal wipes used for the disinfection of the glucometer between residents for one of two sampled residents (Resident #5). Corrective Action for Resident Affected: The licensed nurse was re-educated on the Recommendations for Cleaning and Disinfection of Glucometers-North Carolina Statewide Program for Infection Control and Epidemiology. Corrective Action for Resident Potentially Affected: All residents have the potential to be affected by this practice. On 11 April 2017, the Director of Nursing implemented education on the Recommendations for Cleaning and Disinfection of Glucometers: North Carolina Statewide Program for Infection Control and Epidemiology (SPICE). Following the manufacturer's guidelines using a cloth or wipe with either Environmental Protection Agency (EPA) registered detergent or a dilute bleach solution of 1:10(one part bleach to 9 parts water) to 1:100 concentration after each use of the glucometer	

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F 441	Continued From page 7 dilute bleach solution of 1:10 (one part bleach to 9 parts water) to 1:100 concentration." On 4/11/17 at 4:24PM, Nurse #1 was observed obtaining Resident #4 ' s blood sugar. At 4:52PM, Nurse #1 wiped the surface of the glucometer with an alcohol wipe and began to enter Resident #5 ' s room to check her blood sugar with the same glucometer. At that time, Nurse #1 was asked to step into the hallway. Nurse #1 was interviewed on 4/11/17 at 4:52PM prior to obtaining the blood sample from Resident #5. Nurse #1 stated she was not sure if each resident had their own individual glucometer and used the glucometer that was on the medication cart for her blood sugar checks on the residents. She stated she cleaned the glucometer with an alcohol wipe or a disinfecting wipe between residents and guessed she should have used a germicidal wipe. She was unsure of the time the glucometer should remain wet. A review of the directions of the disinfecting wipe package read, in part, "To sanitize, use enough wipes for treated surface to remain visibly wet for 10 seconds, let surface dry. To disinfect, four minutes." In 4/12/17 at 9:49AM, an interview was conducted with the Director of Nursing who stated the facility followed the SPICE guidelines for disinfection of the glucometers and she expected staff to use the disinfecting wipes to clean the glucometer machine.	F 441	Systemic Changes On 24 April 2017, the Director of Nursing in-serviced all registered nurses and licensed practical nurses the full time, part time and as needed (PRN) licensed nurses. Topic included: Recommendations for Cleaning and Disinfection of Glucometers-North Carolina Statewide Program for Infection Control and Epidemiology (SPICE). The Director of Nursing will ensure that any staff member who did not receive this training by April 28th, 2017 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing, or Minimum Data Set (MDS) or Support Nurse will monitor this issue using the Quality Assurance (QA) Survey Tool, conducting observations that the licensed nurses are following the manufacturer's guidelines using a cloth or wipe with either Environmental Protection Agency (EPA) registered detergent or a dilute bleach solution of 1:10 (one part bleach to 9 parts water) to 1:100 concentration after each use of the glucometer. Any issues will be	

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F 441	Continued From page 8	F 441	reported to the Administrator. This will be done weekly for one month or until resolved by Quality Assurance Committee. All nurses will be audited during this time period. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set (MDS) Coordinator, Support Nurse, Therapy Director or Rehabilitation Aide, Health Information Manager, Dietary Manager and the Administrator. Compliance date: April 28th, 2017	