

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345567 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 03/22/2018 |
|---|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF CORNELIUS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031 | |
| (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 000 | INITIAL COMMENTS | F 000 | | |
| F 641 SS=D | <p>Accuracy of Assessments CFR(s): 483.20(g)</p> <p>§483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of functional limitation in range of motion for 1 of 1 Residents (Resident #57).</p> <p>Findings included: Resident #57 was admitted to the facility on 1/15/2018 with a diagnosis that included hemiplegia and hemiparesis following cerebral infarction affecting right side- dominant side, muscle weakness, and dementia without behavioral disturbance. The MDS indicated Resident #57 was moderately cognitively impaired.</p> <p>Review of the Admission Minimum Data Set (MDS) dated 1/22/2018 revealed Resident #57 required extensive assistance with bed mobility, transfers, dressing, and toileting. Further review of the MDS indicated Resident #57 had no impairment to upper and lower extremities.</p> <p>Review of the Care Area Assessment (CAA) dated 1/22/2018 for Activities of Daily Living functioning/ Rehab Potential revealed Resident #57 had physical limitations/ decreased mobility</p> | F 641 | <p>Based on record review and staff interview the facility failed to accurately code the MDS assessment in the area of functional limitation in range of motion for 1 or 1 residents (resident #57).</p> <p>To remain in compliance with all federal and state regulations the facility has taken 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 corrected by 4/12/18.</p> <p>1. MDS Coordinator submitted an MDS correction on 4/19/2018 for Resident #57. Section G0400A of the MDS dated 1/22/2018 was corrected to reflect functional impairment affecting one side. In addition, a Significant Change Assessment was completed on 3/23/2018 and a correction was also submitted for this assessment to section G0400A to reflect a functional impairment affecting one side. Section I4900 was also modified to "yes" in order to correctly reflect the</p> | 4/12/18 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/12/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 641 | <p>Continued From page 1 for bathing, toileting, locomotion, transfers. Proceed to care plan.</p> <p>Review of the Care Plan dated 1/17/18 revealed a problem/ onset of Resident #57 was at risk for self-care deficit related to decreased mobility. The resident had a goal of having adl's met daily. The interventions included allow the resident rest breaks, assist with shower/ bath per preference, toileting and transfers with extensive assistance of 2 staff persons, and therapy referrals as needed.</p> <p>An observation made on 03/20/18 at 09:18 AM revealed Resident #57 at the main dining area in wheelchair. Resident #57 was finishing her breakfast. Resident #57 was observed not utilizing her right arm or hand.</p> <p>An observation on 03/21/2018 at 10:33 AM revealed staff assisting Resident #57 to room in wheelchair.</p> <p>An interview on 03/22/18 at 10:59 AM with the MDS nurse revealed Resident #57 was coded as having no impairments. The MDS nurse indicated during Resident #57 evaluation for upper and lower impairment, Resident #57 limbs were held. The MDS nurse actively performed range of motion to upper and lower extremities. Per the MDS nurse the range of motion for the resident was not impaired.</p> <p>An interview on 03/22/18 at 11:22 AM with the Administrator revealed that her expectation was that upper and lower extremity impairments be coded accurately on the MDS and to follow the policy in the Resident Assessment Instrument manual.</p> | F 641 | <p>diagnosis of Hemiparesis on the assessment dated 3/23/2018.</p> <p>2. All residents with a diagnosis of hemiparesis were reviewed on 3/23/2018 to ensure accuracy of MDS assessment coding specifically section G0400 functional status coding and review was completed on 3/26/2018.</p> <p>3. Education on accuracy of coding and functional status impairment provided by director of nursing to MDS coordinators on 3/22/2018 and completed on 3/22/2018.</p> <p>4. MDS or designee will conduct an ongoing audit weekly of all MDS assessments to ensure accurate functional status coding prior to completion of the MDS. The results of the observations will be reported, reviewed and trended for compliance through the facilities QAPI program monthly x 12 months.</p> | | |

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| F 761 F 761 SS=D | Continued From page 2 Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to date two opened vials of multi dose Tuberculin Purified Protein Derivative (used to test TB) in 1 of 4 medication rooms (300-400 hall) and failed to date and maintain foil packaging for Ipratropium Bromide and Albuterol Sulfate Inhalation Solution in 1 of 4 medication carts (100-200 hall). | F 761 F 761 | Based on observation and staff interview the facility failed to date two opened vials of multi dose tuberculin purified protein derivative (used to test TB) in 1 of 4 medication rooms (300-400 hall) and failed to date and maintain foil packaging for Ipratropium Bromide and Albuterol Sulfate Inhalation Solution in 1 of 4 medication carts (100-200 hall). | 4/12/18 | |

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| F 761 | <p>Continued From page 3</p> <p>Findings included:</p> <p>Manufacturer's guideline reads in part:</p> <p>Storage Conditions: Once removed from the foil pouch, the individual vials should be used within two weeks. Discard if the solution is not colorless.</p> <p>1. An observation on 03/22/2018 at 12:43 PM of the medication storage room on 300-400 halls revealed two multi dose vials of Tuberculin- Lot #306943 in the refrigerator in a clear plastic zip-lock bag opened, used and not dated. The manufacturer label disclosed that it should be discarded after 30 days after opening.</p> <p>An interview with Nurse #2 on 3/22/2018 at 12:45 PM revealed that he was not certain when the vials were opened. The nurse further indicated that the vials would be discarded.</p> <p>An interview with the Assistant Director of Nursing on 3/22/2018 at 1:43 PM revealed that the vials should have been discarded as they were not dated when opened.</p> <p>2. An observation on 3/22/2018 at 11:28 AM of the medication cart on 100-200 hall revealed that Ipratropium Bromide and Albuterol Sulfate Inhalation Solution was opened on 3/1/2018. The medication was also not in the original foil packaging.</p> <p>An interview with Nurse #4 on 3/22/2018 at 11:33 AM revealed that she keeps the medication in the box in the medication cart. She stated that she was not aware the medication could not be in the medication box without the foil packaging. Nurse</p> | F 761 | <p>To remain in compliance with federal and state regulations the facility has taken 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 corrected by 4/12/18.</p> <p>1. A 100% audit of all areas of medication storage including medication rooms, refrigerators and medication carts was completed by the director of nursing on 3/22/18.</p> <p>2. All residents have the potential to be effected. Licensed nursing staff have been in serviced by director of nursing and assistant director of nursing on proper storage and handling of medications including checking for expiration dates starting on 3/22/18 ending on 4/12/18.</p> <p>3. Director of nursing/assistant director of nursing will complete audits of medication storage areas weekly x8 weeks and monthly x 12 months to identify any expired medications and proper storage.</p> <p>4. Director of nursing/assistant director of nursing will check the vaccine refrigerator weekly x 12 months.</p> <p>5. Director of nursing will present findings of audits to the QAPI committee monthly x 12 months.</p> | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 761 | Continued From page 4 #4 also verbalized that medication should have been dated. An interview with the Director of Nursing on 03/22/18 at 02:40 PM revealed that her expectation regarding medication storage and labeling was that medications are dated and labeled when they are opened. Dates should be on the bottle, as well as the box. | F 761 | | | |
| F 842 SS=D | Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; | F 842 | | 4/12/18 | |

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| F 842 | <p>Continued From page 5</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is not met as evidenced by:</p> | F 842 | | | |

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| F 842 | <p>Continued From page 6</p> <p>Based on record review, resident and staff interviews the facility failed to document the correct extremity that blood pressures were obtained for 1 of 1 residents (Resident #42) who had a fistula to the left upper extremity.</p> <p>The findings included:</p> <p>Resident #42 was admitted to the facility on 10/21/16 with a diagnosis that included chronic kidney disease stage 4, nephrotic syndrome with morphologic changes, diabetes mellitus and proteinuria. The most recent Minimum Data Set (MDS) dated 2/3/18 indicated Resident #42 was cognitively intact and required limited assistance with Activities of Daily Living (ADL).</p> <p>Review of the physician's active orders for the months of March 2018 and February 2018 stated "do not take blood pressures (BP's) in the arm with the dialysis access site. NO BP's on LEFT ARM."</p> <p>Review of Resident #42's documented vital signs from September 2017 through March 2018 revealed 59 entries of blood pressure taken on the left arm.</p> <p>An interview was conducted on 3/21/18 with Nurse #1 at 3:26pm. Nurse #1 stated the Nursing Assistants (NA) would get a full set of vital signs to include blood pressure. All NA's were aware to use the right arm because of the shunt site was located in the left arm. Nurse #1 further stated the NA's do not document vital signs. They inform the nurses of the vitals and the nurses put the vital signs in the electronic medical record. Nurse #1 indicated that although she was aware the blood pressure was taken on the right arm the system</p> | F 842 | <p>Based on record review, resident and staff interviews the facility failed to document the correct extremity that blood pressures were obtained for 1 of 1 residents (resident #42) who had a fistula to the left upper extremity.</p> <p>To remain in compliance with all federal and state regulations the facility has taken 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 corrected by 4/12/18.</p> <p>1. Vital sign documentation was corrected electronically in the chart of resident #42 on 3/22/2018 to reflect correct method specifically site used to obtain the residents blood pressure. Correction of documentation was completed on 3/23/2018. Sign stating "No Blood pressure, blood draws, IV's on left arm" placed above bed in the room of resident #42. Additional sign stating "Nurse to obtain residents BP" placed above bed of resident #42.</p> <p>2. 100% audit of all residents completed on 3/22/2018 to ensure all resident requiring specific instructions for vital signs had appropriate sign placed in their room and corresponding order in their electronic chart.</p> <p>3. 100% education completed by director of nursing with all nursing staff regarding vital sign policy starting on 3/22/18 ending</p> | | |

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| F 842 | <p>Continued From page 7</p> <p>would default to the left arm. She stated to correct this error she would have to manually correct it and she stated she does not correct the defaulted left arm.</p> <p>An interview was conducted on 3/21/18 with Resident #42 at 4:52pm. Resident #42 revealed the facility staff took her blood pressure in her right arm. Resident #42 further indicated she occasionally had to remind staff to not use her left arm to obtain blood pressures. Resident #42 stated she had to remind staff more often recently. She further stated when she first had the fistula placed, there was a sign above her bed. Resident #42 reported she didn't know what happened to the sign but stated she wouldn't mind it being put back up.</p> <p>An interview was conducted on 3/22/18 with Nurse #2 at 9:14am. Nurse #2 stated he got his own vital signs especially with Resident #42 who received dialysis. Nurse #2 further stated he would take the blood pressure on the opposite arm of the accessed site. Nurse #2 revealed the reason the left arm was documented in the medical record was order entry error due to him being in a rush. Nurse #2 further revealed the computer default was the left upper arm so whomever had included the vital signs had to change the defaulted left upper arm to the correct arm.</p> <p>An interview was conducted on 3/22/18 with Nurse #3 at 9:26am. Nurse #3 stated she would get her own vital signs for Resident #42 who received dialysis. Nurse #3 further stated Resident #42 was the only resident in the facility that received dialysis and she had a shunt in her left upper arm so all vital signs are taken on the</p> | F 842 | <p>on 4/12/18.</p> <p>4. Administrative nursing team will check nursing documentation of vital signs for residents with specific accommodations in weekly risk meeting to ensure accuracy of documentation.</p> | | |

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| F 842 | Continued From page 8 right upper extremity. Nurse #3 revealed the reason for the inaccurate blood pressure on the left upper extremity was either due to a clerical error or the medical record system defaulting. An interview was conducted on 3/22/18 with the Director of Nursing (DON) at 10:52am. The DON stated her expectation is to correctly document all vital signs including the correct site it was taken. The DON further stated the system would default to the left upper arm but she expects staff to change the system defaulted site. An interview was conducted on 3/22/18 with the Administrator at 11:02am. The Administrator stated it was her expectation that all vital signs entered into the medical record be accurate including the site it was taken. The Administrator further indicated she expected the staff to change the system defaulted site. | F 842 | | | |
| F 867 SS=D | QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in January 2017. This was for one recited deficiency which was originally cited in January 2017 during a | F 867 | Based on record review and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in January 2017. This was for one recited deficiency which | 4/12/18 | |

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| F 867 | Continued From page 9 recertification survey and was subsequently recited in March 2018 on an annual recertification survey. The deficiency was in the area of drug records, label/ storage and biologicals. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: F761 Drug records, label/ storage and biologicals: Based on observation and staff interview the facility failed to date two opened vials of multi dose Tuberculin Purified Protein Derivative (used to test TB) in 1 of 4 medication rooms (300-400 hall) and failed to date and maintain foil packaging for Ipratropium Bromide and Albuterol Sulfate Inhalation Solution in 1 of 4 medication carts (100-200 hall). An interview on 03/22/18 at 02:27 PM with the Administrator revealed that last year's plan of correction continues to be worked. The Director of Nursing or designee checked the refrigerator on Friday (last week) and tossed an opened Tuberculin, but did not check the other two bottles. The Administrator indicated that she was uncertain as to why this issue was still occurring. | F 867 | was originally cited in January 2017 during a recertification survey and was subsequently recited in March 2018 on an annual recertification survey. The deficiency was in the area of drug records, label/ storage and biologicals. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. To remain in compliance with all federal and state regulations the facility has taken 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 corrected by 4/12/18. 1. Director of nursing/assistant director of nursing will complete audits of medication storage areas weekly x8 weeks and monthly x12 months to identify any expired medications and proper storage. 2. Director of nursing/nursing management will check the vaccine refrigerator weekly x12 months. 3. Director of nursing will present findings of audits to the QAPI committee x12 months. | | |
| F 880 SS=D | Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and | F 880 | | 4/12/18 | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 880 | <p>Continued From page 10</p> <p>comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the</p> | F 880 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345567 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 03/22/2018 |
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| F 880 | <p>Continued From page 11 circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure blood glucose meters (glucometers) were properly disinfected/sanitized after use during 2 of 2 observations (Resident #19 and Resident #59) of a glucometer use.</p> <p>Findings included:</p> <p>Review of facility policy titled "Nursing- Cleaning of Glucometer Machines" dated 2/20/2007 read in part:</p> <p>Policy- Facility shall clean and sanitize glucometer machines after each use.</p> <p>Procedure- Glucometer machines shall be</p> | F 880 | <p>Based on observations and staff interviews the facility failed to ensure blood glucose meters (glucometers) were properly disinfected/sanitized after use during 2 of 2 observations (Resident #19 and Resident #59) of a glucometer use.</p> <p>To remain in compliance with all Federal and State regulations the facility has taken 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 corrected by 4/12/18.</p> <p>1. Glucometers for both resident #19 and</p> | | |

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| F 880 | <p>Continued From page 12</p> <p>cleaned after each use by nursing personnel. 1- Wear gloves 2- Wipe machine using Germicidal wipes 3- Machine must be disinfected after each use 4- If problem occurs with machine notify nursing supervisor.</p> <p>A review of the manufacturer's instruction label for disinfection using germicidal wipes read in part:</p> <p>Disinfection directions- Thoroughly wet pre-cleaned, hard, non-porous surface with a wipe, keep wet for 2 minutes (5 minutes if fungus is suspected) and allow to air dry. Use as many wipes as needed for the treated surface to remain wet for the entire contact time.</p> <p>1. An observation was conducted on 3/22/2018 at 11:20 AM of Nurse #4 obtaining a finger stick blood sugar (FSBS). Nurse #4 was observed entering Resident #19's room to obtain a FSBS. Nurse #4 returned to the medication cart, wiped the glucose meter (glucometer) with a germicidal wipe. She then tossed the wipe into the trash bin, and placed the glucometer in the medication cart. Continuous observation and timing of the glucometer revealed the surface appeared dry in less than 45 seconds. Nurse #4 did not ensure the glucometer remained wet with germicidal solution for a full 2 minutes.</p> <p>An interview with Nurse #4 on 3/22/2018 at 11:25 AM revealed it was facility procedure after utilizing a glucometer to wipe the glucometer down with a germicidal wipe. Nurse #4 indicated that the glucometer did not remain visibly wet for 2 minutes. Nurse #4 then read the instructions on the container of germicidal wipes and stated she was unaware of the need to ensure the</p> | F 880 | <p>resident #59 were immediately disinfected/sanitized upon notification of deficient practice on 3/22/2018 and prior to next use for each individual resident. Nurses followed appropriate disinfection procedures which were verbally reviewed with both nurses in person on 3/22/2018. Glucometers were not utilized prior to disinfection and proper sanitation.</p> <p>2. Licensed nursing staff have been in-serviced by Director of Nursing and Assistant Director of Nursing on the policy of disinfecting glucometers properly starting on 3/22/18 and ending on 4/12/18.</p> <p>3. Director of Nursing or Assistant Director of Nursing audits of 4 nurses x 4 weeks beginning 3/23/2018 to ensure proper disinfecting procedures are routinely being followed.</p> <p>4. Random med pass observations will be completed by Director of Nursing or Assistant Director of Nursing beginning April 23, 2018 . This will be an ongoing process in addition to the new hire and annual med pass evaluation competency. Findings will be reported to the administrator and will be reviewed in monthly and quarterly QAPI meetings x 6 months with corrective action as warranted. Frequency of observations will be adjusted according to the outcomes.</p> | | |

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| F 880 | <p>Continued From page 13</p> <p>glucometer remained wet with germicidal solution for 2 minutes to complete the disinfecting process.</p> <p>2. An observation was conducted on 3/22/2018 at 12:06 PM of Nurse #2 obtaining a finger stick blood sugar (FSBS). Nurse #2 was observed entering a Resident #59's room to obtain a FSBS. Nurse #2 returned to the medication cart, and wrapped the glucose meter (glucometer) with a germicidal wipe. He then placed the wrapped glucometer in a cup and placed the cup containing the wrapped glucometer on the corner of the medication cart. Continued observation and timing of the wrapped glucometer revealed that it remained visibly wet for the 2 minute time frame. Nurse #2 then proceeded to get the clear zip-lock storage bag out of the medication cart, unwrapped the glucometer and placed the glucometer in the zip-lock storage bag. Nurse #2 did not allow the glucometer to air dry.</p> <p>An interview with Nurse #2 on 3/22/2018 at 12:11 AM revealed that he lets the glucometer remain in cup wrapped with sani-wipe for approximately 2 minutes or until he remembers to remove it. He further indicated that he was not aware that glucometer's needed to air dry prior to placing in the zip-lock storage bag.</p> <p>An interview with the Director of Nursing on 03/22/2018 at 02:40 PM revealed that her expectation regarding cleaning glucometers was that glucometers are cleaned per facility policy and manufacturer's guidelines.</p> | F 880 | | | |