| | | ID HUMAN SERVICES | | | | RM APPROVED |
|--------------------------|---|---|---------------------|---|---------|----------------------------|
| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | O. 0938-0391 |
| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 、 <i>′</i> | | | E SURVEY IPLETED |
| | | 345406 | B. WING | | 0; | C 3/28/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | I | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| ACCORDI | US HEALTH AND REHAI | BILITATION | | 38 CARTERS ROAD GATESVILLE, NC 27938 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENTS | | F 00 | D | | |
| F 761 | corrected as of this su new tags were cited a investigation survey t same time as the revi compliance. | 40, F 641 and F 867 were urvey's exit date. However, as a result of the complaint hat was conducted at the isit. The facility is still out of | F 76 | 1 | | 4/11/18 |
| SS=D | | - | F 70 | | | 4/11/10 |
| | Drugs and biologicals | y and cautionary | | | | |
| | §483.45(h) Storage o | f Drugs and Biologicals | | | | |
| | Federal laws, the faci biologicals in locked of | ordance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys. | | | | |
| | locked, permanently a storage of controlled the Comprehensive E Control Act of 1976 a abuse, except when t package drug distribu quantity stored is min be readily detected. | cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and nd other drugs subject to he facility uses single unit ation systems in which the imal and a missing dose can | | | | |
| | DIRECTOR'S OR PROVIDER! | SUPPLIER REPRESENTATIVE'S SIGNATUR | | TITLE | | (X6) DATE |
| | cally Signed | | - | | | 04/11/2018 |

Electronically Signed

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.

| | | MEDICAID SERVICES | | | | NO. 0938-03 | |
|---|-----------------------|---|------------------------------------|---|------------------------|----------------------------|--|
| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 、 <i>′</i> | | · · · | ATE SURVEY OMPLETED | | |
| | | | A. BUILDING | | | с | |
| | | 345406 | B. WING | | | | |
| NAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C | | 03/28/2018 | | |
| NAME OF PROVIDER OR SUPPLIER | | | | 38 CARTERS ROAD | ODL | | |
| ACCORDIUS HEALTH AND REHABILITATION | | | | GATESVILLE, NC 27938 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T | ION SHOULD BE | (X5) COMPLETION DATE | |
| IAO | | | | DEFICIENC | | | |
| F 761 | Continued From pag | o 1 | F 76 | | | | |
| 1 /01 | | on and staff interviews the | | | ubmitted as | | |
| | | an unattended medication | | The plan of correction is su | | | |
| | - | of 2 medications carts | | required under Federal and regulation and statues appl | | | |
| | observed. | or 2 medicalions carls | | term care providers. This p | | | |
| | | | | correction does not constitu | | | |
| | The findings included | 4. | | admission of liability on the | | | |
| | | J. | | facility, and such liability is | | | |
| | On 3/28/2018 at 0.33 | 2 AM, a medication cart was | | specifically denied. The sub | - | | |
| | | ext to Room 111 in the B | | plan does not constitute an | | | |
| | | lock observed to be in the | | the facility that the surveyor | | | |
| | | rse was not in view of the | | conclusions are accurate, t | | | |
| | | ne open resident room doors | | constitute a deficiency cited | | | |
| | | from the cart. The nurse | | applied. | | | |
| | | Irn to the cart within 2 | | applied. | | | |
| | | a resident's room 1 door | | F0761 | | | |
| | - | ne location of the cart. There | | 10/01 | | | |
| | | bserved in the hallway near | | 1.Corrective action for the r | residents | | |
| | the cart at the time. | Served in the naliway hear | | affected by the alleged defi | | | |
| | | | | of an unlocked med cart an | | | |
| | During an interview o | on 3/28/108 at 9:34 AM with | | in-servicing done to teach t | | | |
| | | I she could see the cart at all | | current procedure and polic | | | |
| | | in the resident's room. The | | meds and locking med cart | | | |
| | | e thought she would be right | | med passes. To ensure pro | - | | |
| | | she had to pull the resident | | procedures are being follow | | | |
| | | gave him his medications. | | the cart must be in the door | | | |
| | | gave him no modications. | | patient you are passing me | • | | |
| | On 3/28/2018 at 12.2 | 29 PM, an interview was | | that it is visible at all times. | | | |
| | | ursing supervisor. The | | 2.Corrective action taken for | or the residents | | |
| | | he medication cart was in the | | having the potential to be a | | | |
| | | e was not in front of it, the | | alleged deficient practice: F | | | |
| | cart should be locked | | | may have altered cognition | | | |
| | | - | | med seeking may have the | | | |
| | On 3/28/2018 at 1:52 | 2 PM, an interview was | | affected. Nurses that pass | • | | |
| | | dministrator who stated she | | medication pass audits/ cor | | | |
| | | ition cart to be locked when | | the staff development coord | | | |
| | the nurse was away | | | follow-up to survey. | | | |
| | | | | 3.Measures/ Systematic ch | anges put in | | |
| | | | | place to ensure the alleged | | | |
| | | | | not re occur: Licensed nurs | | | |

Event ID: RK1T11

Facility ID: 923158

If continuation sheet Page 2 of 7

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | D: 05/01/2018 MAPPROVED D. 0938-0391 |
|-------------------------------------|---|--|--------------------|--|--|---|--|
| STATEMENT | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345406 | | , <i>'</i> | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | E SURVEY PLETED |
| | | | B. WING | | | | C / 28/2018 |
| NAME OF P | NAME OF PROVIDER OR SUPPLIER | | | ST | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 00 | |
| ACCORDIUS HEALTH AND REHABILITATION | | | | | 3 CARTERS ROAD ATESVILLE, NC 27938 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 761 F 880 SS=D | CFR(s): 483.80(a)(1)(§483.80 Infection Cor The facility must estal infection prevention a designed to provide a comfortable environm development and trar diseases and infection §483.80(a) Infection p program. The facility must estal and control program (a minimum, the follow | & Control (2)(4)(e)(f) htrol blish and maintain an nd control program a safe, sanitary and bent and to help prevent the hismission of communicable ins. prevention and control blish an infection prevention (IPCP) that must include, at | | 880 | serviced by DON/SDC designee on por and procedure for administering medication and cart policies. Active nurses will have completed the in serv and competency training by the date of compliance. PRN nurses will be completed prior to first scheduled shift 4. Corrective actions will be monitored ensure the alleged deficient practice w not re occur: The DON/Designee will Conduct random audits for med passe and watching nurses with carts on the no less than 1x per day 5 x weekly x 4 weeks on all units and rotating shifts to ensure proper procedure is followed. Audits will continue monthly x3 months and then quarterly until 100% complian is achieved. Any negative results will result in additional training before bein able taking the next scheduled shift. | ice f to rill es hall o | 4/11/18 |

If continuation sheet Page 3 of 7

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | M APPROVED D. 0938-0391 | |
|---|--|---|---|-----------------|---|----------------|----------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345406 | | | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | |
| | | B. WING | | | C 03/28/2018 | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | • | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| ACCORDI | US HEALTH AND REHA | BILITATION | | | 38 CARTERS ROAD GATESVILLE, NC 27938 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | IX i | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | _D BE COMPLETI | | |
| F 880 | and communicable di staff, volunteers, visite providing services un arrangement based u conducted according accepted national sta §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility (ii) When and to whor communicable disease reported; (iii) Standard and trar to be followed to prev (iv)When and how isco resident; including bu (A) The type and dura depending upon the in involved, and (B) A requirement that least restrictive possil circumstances. (v) The circumstances must prohibit employed disease or infected se contact will transmit th (vi)The hand hygiene by staff involved in dir | g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following ndards; standards, policies, and ogram, which must include, lance designed to identify ole diseases or can spread to other can spread to other can spread to other can spread to other can spread of infections; blation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ole for the resident under the s under which the facility ees with a communicable cin lesions from direct a or their food, if direct ne disease; and procedures to be followed rect resident contact. | F | 880 | | | | |

Facility ID: 923158

If continuation sheet Page 4 of 7

| | - | ND HUMAN SERVICES | | | | FOR | D: 05/01/201 APPROVE <u>0. 0938-039</u> | | |
|---|--|--|---------------------|--------------------------------------|--|-------------------------|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345406 | | | | 2) MULTIPLE CONSTRUCTION BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
| | | B. WING | | | C 03/28/2018 | | | | |
| NAME OF PROVIDER OR SUPPLIER | | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | • | | | |
| ACCORDIUS HEALTH AND REHABILITATION | | | | | CARTERS ROAD | | | | |
| | | | | G/ | ATESVILLE, NC 27938 | | | | |
| (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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION DATE | | |
| F 880 | Continued From page | e 4 | F 8 | 880 | | | | | |
| | corrective actions tak | en by the facility. | | | | | | | |
| | §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. | | | | | | | | |
| | IPCP and update the | view. ict an annual review of its ir program, as necessary. 「 is not met as evidenced | | | | | | | |
| | Based on observation and staff interviews the facility failed to disinfect a glucometer per the manufacturer's recommendations before use to check blood sugar for 1 of 1 resident (Resident #2) observed for blood sugar check. | | | | The plan of correction is submitted required under Federal and State regulation and statues applicable to term care providers. This plan of correction does not constitute an | | | | |
| | The findings included | | | | admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission | of the | | | |
| | Glucose Level," listed disinfect reusable equacording to the man | led "Obtaining a Fingerstick d for Step #18. Clean and uipment between uses ufacturer's instructions and rol standards of practice. | | | plan does not constitute an agreement the facility that the surveyors' finding conclusions are accurate, that the fin constitute a deficiency cited are corr applied. | ls or ndings | | | |
| | cleaning and disinfec | turer's recommendations for ting were reviewed, and the | | | F0880 | | | | |
| | germicidal/disinfectar visible on the wipe co surface must remain | mmended ht wipes. The manufacturer ht wipe instructions were ontainer as follows: "Treated visibly wet for one minute to infection of all pathogens | | | 1.Corrective action for the residents affected by the alleged deficient pra- of an unlocked med cart are 100% r in-servicing done to teach the staff of current procedure and policies for cleaning glucometers after taking blo sugars. | ourse of the bood | | | |
| | | AM, Nurse #2 was m #117 and place the ed cart and take her gloves | | | 2.Corrective action taken for the res having the potential to be affected b alleged deficient practice: Residents may have diabetes may have the po | y the that | | | |

Facility ID: 923158

| TATEMENT (| DF DEFICIENCIES | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | LE CONSTRUCTION | | MB NO: 0938-03 X3) DATE SURVEY COMPLETED | | |
|-------------------------------------|---|---|---------------------|---|--|--|--|--|
| | CONNECTION | BENTIFICATION NOWIDER. | A. BUILDING | A. BUILDING | | | | |
| | | 345406 | B. WING | | | | | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CI | TY, STATE, ZIP CODE | 03/28/2018 | | |
| ACCORDIUS HEALTH AND REHABILITATION | | | | 38 CARTERS ROAD | | | | |
| | | | | GATESVILLE, NC | 27938 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CO | IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIAT DEFICIENCY) | (X5) COMPLETIC E DATE | | |
| F 880 | Continued From page | e 5 | F 88 | 0 | | | | |
| | Continued From page 5 off and discard them. The nurse stated she had checked the resident's blood sugar from the "B" bed, and she was now going to pass meds to the resident in Bed A. The nurse used hand sanitizer and prepared the medications for the resident, which included insulin. On 3/28/2018 at 8:58 AM, the nurse inserted a new blood test strip into the glucometer, picked up the glucometer, lancet, and medications including insulin pen, and entered the resident's room. The nurse stated she was going to administer the medications first then check the resident's blood sugar before administering the insulin. After the medications were given, the nurse was asked about the cleaning of the glucometer, since she had used it previously with the roommate. The nurse stated she was supposed to wipe the glucometer with purple wipes, but was nervous with someone watching her and forgot. The nurse took the glucometer, insulin and supplies back out to the cart, laid the glucometer directly on the cart and looked for the purple wipes, which were not on the cart. The nurse left to find the wipes. On 3/28/2018 at 9:05AM, the nurse arrived back at the cart at with a container of purple wipes, and wiped the glucometer for 10 seconds and laid the glucometer directly on the medicine cart. The nurse stated the glucometer needed to be wiped for 5 to 10 seconds, and then after a minute the germs would be killed. The nurse was requested | | | to be affected. prevention aud staff developm follow-up to su 3.Measures/ S place to ensur not re occur: L serviced by D0 and procedure glucose testing Active nurses service and co date of compli completed priot 4. Corrective a ensure the alle not re occur: T Conduct rando hall no less tha weeks on all u ensure proper Audits will con and then quar is achieved. A result in additii able taking the All residents w have been pro of 3/28/18. Th | Nurses will pass infection dits/ competencies by the nent coordinator as a urvey. Systematic changes put in re the alleged practice does icensed nurses will be in ON/SDC designee on polic for administering blood g with glucometer policies. will have completed the in ompetency training by the fance. PRN nurses will be or to first scheduled shift. actions will be monitored to eged deficient practice will The DON/Designee will om audits for BG's on the an 1x per day 5 x weekly x units and rotating shifts to procedure is followed. tinue monthly x3 months terly until 100% complianc ny negative results will onal training before being e next scheduled shift. with diabetic testing needs ovided their own monitor as ey are properly labeled an opatients room in individual | s Cy c 4 e s | | |
| | nurse was interviewe | AM, the infection control d in the presence of Nurse the directions on the wipe | | | | | | |

If continuation sheet Page 6 of 7

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED C NAME OF PROVIDER OR SUPPLIER 345406 STREET ADDRESS, CITY, STATE, ZIP CODE 38 CARTERS ROAD GATESVILLE, NC 27938 O3/28/20 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (COMPLETED COMPLETED C | | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | | FORM |): 05/01/2018 APPROVED). 0938-0391 |
|--|-------------|---|---|---------|--|------------------------------|----------|------|---|
| 345406 B. WING O3/28/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ACCORDIUS HEALTH AND REHABILITATION STREET ADDRESS, CITY, STATE, ZIP CODE 36 CARTERS ROAD GATESVILLE, NC 27938 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 880 Continued From page 6 container, stated the glucometer needed to be wet for one minute, then laid on a clean tissue and allowed to air dry. F 880 F 880 On 3/28/2018 at 12:29 PM, an interview was conducted with the nursing supervisor, who stated the glucometer should be cleaned at the start of each shift and between each resident. She indicated the glucometer was to be cleaned with the disinfectant wipe for 1 minute, then put on a clean paper towel to air dry before using. On 3/28/2018 at 1:52 PM, an interview was conducted with the Administrator, who stated she expected the glucometer to be cleaned per facility On 3/28/2018 at 1:52 PM, an interview was | STATEMENT O | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | . , | | | | | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ACCORDIUS HEALTH AND REHABILITATION 38 CARTERS ROAD GATESVILLE, NC 27938 (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) COM COM COM COM COM COM COM COM COM COM | | | 345406 | B. WING | | | | | |
| ACCORDIUS HEALTH AND REHABILITATION GATESVILLE, NC 27938 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COME F 880 Continued From page 6 container, stated the glucometer needed to be wet for one minute, then laid on a clean tissue and allowed to air dry. F 880 F 880 On 3/28/2018 at 12:29 PM, an interview was conducted with the nursing supervisor, who stated the glucometer was to be cleaned with the disinfectant wipe for 1 minute, then put on a clean paper towel to air dry before using. On 3/28/2018 at 1:52 PM, an interview was conducted with the Administrator, who stated she expected the glucometer to be cleaned per facility On 3/28/2018 at 1:52 PM, an interview was | NAME OF PI | NAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, | ZIP CODE | | |
| GATESVILLE, NC 27938 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COM F 880 Continued From page 6 container, stated the glucometer needed to be wet for one minute, then laid on a clean tissue and allowed to air dry. F 880 F 880 On 3/28/2018 at 12:29 PM, an interview was conducted with the nursing supervisor, who stated the glucometer should be cleaned at the start of each shift and between each resident. She indicated the glucometer was to be cleaned with the disinfectant wipe for 1 minute, then put on a clean paper towel to air dry before using. On 3/28/2018 at 1:52 PM, an interview was conducted with the Administrator, who stated she expected the glucometer to be cleaned per facility | ACCORDI | US HEALTH AND REHA | BILITATION | | | | | | |
| PREFX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMI F 880 Continued From page 6 container, stated the glucometer needed to be wet for one minute, then laid on a clean tissue and allowed to air dry. F 880 F 880 F 880 Conducted with the nursing supervisor, who stated the glucometer should be cleaned at the start of each shift and between each resident. She indicated the glucometer was to be cleaned with the disinfectant wipe for 1 minute, then put on a clean paper towel to air dry before using. On 3/28/2018 at 1:52 PM, an interview was conducted with the Administrator, who stated she expected the glucometer to be cleaned per facility On 3/28/2018 at 1:52 PM, an interview was On 3/28/2018 at 1:52 PM, an interview was | | | | | 0 | GATESVILLE, NC 27938 | | | |
| container, stated the glucometer needed to be wet for one minute, then laid on a clean tissue and allowed to air dry. On 3/28/2018 at 12:29 PM, an interview was conducted with the nursing supervisor, who stated the glucometer should be cleaned at the start of each shift and between each resident. She indicated the glucometer was to be cleaned with the disinfectant wipe for 1 minute, then put on a clean paper towel to air dry before using. On 3/28/2018 at 1:52 PM, an interview was conducted with the Administrator, who stated she expected the glucometer to be cleaned per facility | PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | PREF | PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI | | | | (X5) COMPLETION DATE |
| conducted with the Administrator, who stated she expected the glucometer to be cleaned per facility | F 880 | container, stated the g wet for one minute, th and allowed to air dry On 3/28/2018 at 12:2 conducted with the nu stated the glucometer start of each shift and She indicated the gluc with the disinfectant v | glucometer needed to be nen laid on a clean tissue 7. 9 PM, an interview was ursing supervisor, who r should be cleaned at the I between each resident. cometer was to be cleaned vipe for 1 minute, then put | F | 880 | | | | |
| FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: RK1T11 Facility ID: 923158 If continuation sheet Page | | conducted with the Ad expected the glucome policy. | dministrator, who stated she eter to be cleaned per facility | | | | | | |