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	345116	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT HILLS CENTER FOR NURSING AND REHAB	109 S HOLDEN RD GREENSBORO, NC 27407

(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 An unannounced onsite complaint investigation was conducted on 7/10/24 through 7/11/24. Additional information was obtained off site on 7/12/24 and the credible allegation of immediate jeopardy removal was validated on 7/17/24. Therefore, the exit date was changed to 7/17/24. Event ID #REEK11. The following intakes were investigated: NC00218858 and NC00219146. 3 of the 3 complaint allegations did not result in deficiency. Immediate Jeopardy was identified at: CFR 483.80 at tag F880 at a scope and severity K CFR 483.35 at tag F726 at a scope and severity K Immediate Jeopardy began on 7/10/24 and was removed on 7/12/24.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other	F 609		8/1/24

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

Electronically Signed | 07/25/2024

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F 609	Continued From page 1 officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to submit a 24-hour and 5-day report to the State Agency when the facility became aware of an allegation of misappropriation of property by a staff member on 7/5/24 for 1 of 3 residents reviewed for misappropriation of resident property (Resident #2). Findings included: A review of the facility's undated Abuse, Neglect and Exploitation policy defined "Alleged Violation" as a "situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property." Under Reporting/Response, the policy stated "A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the	F 609	Without admitting or conceding either the existence or scope or severity of the deficiencies, Piedmont Hills Center for Health and Rehabilitation submits this plan of correction to be in compliance with the regulations. F609 An Initial Allegation misappropriation report was sent to the State Agency regarding the misappropriation of resident property on July 19, 2024, for resident #2. Initial Allegation Reports for the last 30 days were reviewed for submission in the allotted time. Current residents and/or their RP were interviewed regarding misappropriation of resident property concerns they might have. Residents with a BIMS of 12 or higher were interviewed for any concerns with misappropriation of resident property with intervention as deemed needed. Any resident with a BIMS of 11 or lower their RR was contacted for any concerns with misappropriation of resident property with	

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F 609	Continued From page 2 Administrator, state agency, adult protective services and to all required agencies (e.g. law enforcement when applicable) within specified timeframes: a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury ...B. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the investigation when final within 5 working days of the incident, as required by state agencies." Review of the initial investigation documents provided by the facility on 7/11/24 revealed a letter from the North Carolina Board of Nursing (NCBON) dated 7/8/24. The letter indicated a complaint had been received alleging Nurse #2 may have diverted controlled substances on or about 7/6/24. Another document indicated Nurse #2 voluntarily underwent drug testing on 7/8/24. The initial result indicated the urine specimen collected was negative for oxycodone. Review of Resident#2's pain medication oxycodone 10 milligram (mg) narcotic sheet on 7/11/24 revealed: The narcotic sheet was labeled with Resident #2's identifier and a current order that stated, "take 1 tablet by mouth every six hours as needed." The narcotic count on 7/2/24 revealed there were 28 tablets as of 7:39 am. On 7/2/24 at 1:39 pm, Nurse #2 administered 1 tablet and documented there were 27 tablets remaining. On 7/2/24 at "73 pm", Nurse #2 administered 1 tablet and documented there were 26 tablets remaining.	F 609	intervention as deemed needed. There were no issues identified during these interviews. The Administrator and Director of Nursing were educated on reporting allegations in the proper timeframe. This education was provided on July 24, 2024, by the Regional Director of Operations. The staff developer will provide education to staff on reporting of misappropriation during the week ending 7/31/24. Any new hires entering the facility will receive education on reporting misappropriation of resident property during orientation. The Administrator or designee will audit three Initial Allegation Reports of misappropriation of resident property weekly for four weeks, then twice a week for eight weeks for reporting completion in the two-hour window. The Administrator will also review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	

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On 7/2/24 at "1930", Nurse #2 documented she administered a tablet and documented there were 25 tablets remaining. At the bottom of the narcotic sheet was a section to record waste and spoilage. One oxycodone 10 mg tablet was wasted by Nurse #2 as indicated by her signature on 7/2/24. There was no time documented. Nurse #2 wrote "wrong time" under the description/detail column. There was not a second signature to witness the waste under the column for signature #2. The documented wasting of the oxycodone 10 mg tablet on 7/2/24 was marked out by a single line. At the end of the line, Nurse #2 wrote "wrong medication" and the Nurse #2's initials above it.

The documented narcotic count for Oxycodone 10 mg on 7/5/24 at 4:09 am revealed there were 14 tablets. Medication Aide (MA) #1 administered a tablet on 7/5/24 at an undetermined time. The time documented was marked over and was ineligible to read. MA #1 documented the remaining amount was 13 on the narcotic sheet. Nurse #2 documented she administered a tablet on 7/5/24 at 10:00 am and documented the remaining amount was 12. On 7/5/24 at 6:36 pm, Nurse #2 documented the corrected count was eight tablets. Under the record of waste and spoilage, another entry by Nurse #2 as indicated by her signature dated 7/5/24 indicated she wasted oxycodone tablets. The entry under the quantity wasted was illegible. The area under signature #2 column had been blotted out.

During an interview on 7/10/24 at 5:50 pm, Resident #2 stated she was receiving her pain medications as scheduled and did not have any issues with her pain medications.

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During an interview on 7/10/24 at 4:55 pm, MA #1 stated she worked 7:00 am to 7:00 pm on 7/5/24. She revealed there was an issue with the wasted oxycodone tablets for Resident #2 when she was counting off at 7:00 pm with MA #7. She remembered administering 1 oxycodone 10 mg tablet at 10:00 am on 7/5/24 to Resident #2. She explained that there were 13 tablets left when she counted off with Nurse #2 for her lunch break at around 12 noon. MA #1 said she went out to monitor the residents that smoked after supper. She counted off with Nurse #2 again and said there were still 13 oxycodone tablets. At around 6:00 pm, Nurse #2 called her to fix the narcotic count. She revealed Nurse #2 told her there were 3 oxycodone tablets that fell from Resident #2's oxycodone pill card and wanted to waste it with her. MA #2 said Nurse #2 did not produce the three pills that she wanted to waste so she refused to sign as a witness. Nurse #2 told her she threw the 3 pills down the toilet and wanted her to sign. She explained to Nurse #2 that she was not comfortable, so she did not sign the narcotic sheet as a witness. When MA #1 was counting off with MA #7 on 7/5/24 at 7:00 pm, they both noticed there were only 8 oxycodone tablets left for Resident #2 as it was documented on the narcotic sheet. MA #1 informed MA #7 that there were 3 pills wasted by Nurse #2 earlier so the count should have been 10 oxycodone tablets. She also noticed the 10:00 time she entered earlier that day was marked over and was rendered ineligible. In addition, Nurse #2 had documented that she administered another tablet at 10:00 am. Both MA #1 and MA#7 both decided the total should have been 9 oxycodone tablets remaining in the pill card. Both MA's notified Nurse #3 and explained there was a discrepancy in Resident #2's oxycodone count. Nurse #3

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called Nurse #2 to explain what went on. Nurse #2 told Nurse # 3 that she and MA #1 wasted 5 tablets earlier. MA #1 explained to the nurses and MA #7 that Nurse #2 told her she wasted 3 tablets, but she did not see the actual pills to waste. Nurse #2 had already wasted it, so she refused to sign. MA #1 revealed somebody scrawled all over the signature #2 line for 7/5/24 making it look like she signed and blotted off her signature. MA #1 stated she never signed as a witness and left the signature #2 space blank. She revealed Nurse # 3 contacted the Administrator and reported Nurse #2 and the missing narcotics. The Director of Nursing (DON) called back and instructed Nurse #3 to get statements from the MAs and the nurses.

During an interview on 7/11/24 at 7:50 am, Nurse #3 stated MA #1 counted off with night shift MA #7 on 7/5/24 at 7:00 pm. Both MAs noticed a discrepancy with Resident #2's oxycodone count, so they called her. Nurse #3 revealed Nurse #2 documented 3 pills were wasted on the narcotic sheet. When Nurse #2 came, she told MA #1 "remember I wasted it, and I told you that's why I asked you to sign?" MA #1 responded, saying that she did not see the pills and she did not sign as a witness. Nurse #3 revealed the witness signature on the narcotic sheet was blotted over but MA #1 insisted she never signed, and that it was a blank space earlier. Nurse #3 said that was not the first time Nurse #2 was involved in a discrepancy. Nurse #3 revealed Nurse #2 wasted a narcotic medication and did not have any witnesses that signed with her on 7/2/24. Nurse #2 also had signed out oxycodone tablets twice at 7:30 pm on 7/2/24 for Resident #2. Nurse #2 revealed she looked at the medication administration record (MAR) to recheck the time

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of administration but there were no entries by Nurse #2 on 7/2/24. She stated she notified DON on 7/4/24 about 7/2/24 but thought there was nothing done about it. Nurse #3 said she called the Administrator on 7/5/24 at around 7:30 pm and reported Nurse #2 and the missing narcotics. The administrator told Nurse #3 that she would call her back, but it was the DON who called her back and instructed her to get statements from the nurses and the MAs. The DON also told Nurse #3 to make a copy of the narcotic sheet and to take a picture and send it to her.

A telephone interview with Nurse #2 was conducted on 7/11/24 at 2:20 pm in the presence of the Regional Nurse Consultant. Nurse #2 stated she was not at work today due to an investigation. She said she administered the narcotic medications she pulled from the medication carts. She stated she was not sure why the narcotic medications she administered were not in the electronic MAR. She explained she could not enter the narcotic medications into the MAR if the MA was logged in on the computer on the cart. She said she went back to the computer on the desk to log the narcotic administration. Nurse #2 claimed she was not aware her entries were not in the MAR until she was notified on 7/8/24 by the DON. She thought the system was not saving what she entered. She stated she signed out the narcotics from the narcotic sheet as soon as she pulled them and administered them immediately to the residents. Nurse # 2 stated she must have a witness whenever she was wasting a narcotic medication. She revealed on 7/5/24 there were no missing pills. She explained that there were 5 oxycodone tablets in the pill card that were popped open at the back, so she had to waste it with MA #1. She

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claimed MA #1 witnessed her waste the pills and signed as the witness. Nurse #2 stated she counted with MA #1 and made sure that there were correct medications remaining in the pill card. She was not aware of the time that was marked over on the narcotic sheet for 7/5/24. She added that she did not waste an oxycodone tablet on 7/2/24. She marked off what she had documented on Resident #2's narcotic sheet when she realized she wasted another resident's medication.

An interview was conducted on 7/11/24 at 10:15 AM with the Administrator and the DON. The Administrator revealed Nurse #3 called her Sunday night (7/7/24) she thought and notified her of a discrepancy involving Nurse #2. She said that was the first time she was made aware of any narcotic discrepancy. Nurse #3 told her she previously reported another discrepancy with the same nurse to the DON. The Administrator called and asked the DON to reach out to Nurse #3 and request statements. The DON stated she requested the Staff Development Coordinator to educate the nurses and medication aides on the accounting of narcotics medications. The DON reached out to Nurse #2 on 7/8/24 and did an investigation. The DON stated she notified the Administrator and the Chief Nursing Officer. She also talked to the North Carolina Board of Nursing (NCBON) investigator, but no one came by to investigate. The Administrator revealed she did not notify the state agency because "we have not determined that's not what happened." She said Nurse #2 did not work on Monday, but she worked Tuesday and Wednesday to assist with computer assessments. The Administrator revealed there was a meeting with the CNO and the nursing team the morning of 7/11/24 and

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removed Nurse #2 from the schedule while the investigation was ongoing.

During a follow up interview on 7/12/23 at 4:10 pm, the Administrator clarified that she was not the one who notified NCBON. She revealed that Nurse #2 called her on 7/8/24 at around 1:00 pm and reported that she received notification from NCBON about a complaint. She stated it was the DON that called the nurse investigator to consult and follow up with her regarding the complaint. She stated Nurse # 3 called her on 7/5/24 and not Sunday night (7/7/24). Nurse #3 told her that she had concerns about Nurse #2 and the narcotic count. Nurse #3 told her that she had previously discussed her concerns about Nurse #2 and narcotics with the DON so she called the DON to follow up with Nurse #3. The Administrator asked the DON to put together all the statements on 7/8/24. She revealed she did not report it to the state agency because "it was just a suspicion", and she "did not have a documented proof that it happened." She stated it was more of a "conversation with Nurse #3 and not an accusation."

On 7/12/24 at 4:40 pm, the Administrator and the Director of Nursing called back to clarify that the report from Nurse #3 on 7/5/23 was not an allegation. The Administrator stated it was more of a discussion that Nurse #2 wasted narcotics and that somebody signed as a witness then it was marked off. The DON stated she started an investigation right that moment and notified the management team within 2 hours. She took statements to look at what was going on. The Administrator stated Nurse #2 called her on 7/8/24 informing her that she was reported to the NCBON about the narcotics. She had Nurse #2

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F 609	Continued From page 9 forward the email from the NCBON to the DON. The DON revealed she talked to the NCBON investigator and obtained guidance on how to proceed. She was told to continue gathering statements and to send the NCBON investigator copies of the statements. The Administrator stated she did not report to the state agency when she was notified by Nurse #2 about her being reported to the NCBON for diversion of controlled substances. The Administrator stated she would consult with the corporate office and would call the surveyor back when she was asked what her training was on notification if she received reports of alleged violations. The Administrator did not call back on 7/12/24.	F 609		
F 726 SS=K	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not	F 726		8/1/24

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F 726	Continued From page 10 limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, Nurse Practitioner and staff interviews, the facility failed to verify competency for cleaning and disinfecting glucometers according to the manufacturer's instructions. Medication Aide (MA) #1 was observed to conduct a finger stick blood sugar (FSBS) check on Resident #1 and using the same shared glucometer proceeded to check blood sugar levels on Resident #2, Resident #3, and Resident #4 without disinfecting the glucometer between any of the residents. MA #1 was interviewed and reported she worked at the facility for approximately 2 years and her competencies for cleaning and disinfecting glucometers per the manufacturer's instructions had never been verified. She stated she never cleaned and disinfected the glucometer between residents. This was for 1 of 1 Medication Aide reviewed. The Immediate Jeopardy began on 7/10/24 when the failure to verify the competency of MA #1 on the cleaning and disinfecting of a glucometer resulted in the MA's failure to clean and disinfect a shared glucometer between residents when conducting FSBS checks. Immediate Jeopardy was removed on 7/12/24 when the facility	F 726	F726 Nurses and/or medication aides have been verified with competency skills in cleaning and disinfecting glucometers according to the manufacture's guidelines completed by July 11, 2024. Resident #1, resident #2, resident # 3 and resident # 4 were provided with individual labeled glucometers in their room on July 11, 2024. Residents who require glucometers were provided with individual labeled glucometers in their room on July 11, 2024. This was performed and verified by the nursing administrative team. Any licensed nurse and/or medication aide was verified by return demonstration the proper cleaning and disinfection of glucometers as deemed needed according to manufacturer's guidelines on July 11, 2024. Education was provided to licensed nurses and/or medication aides on the cleaning and disinfecting of glucometers per manufacturer guidelines by July 12, 2024. Any new hires entering the facility will receive education on the cleaning and	

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F 726	Continued From page 11 implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of E (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems is put in place and to complete employee in-service training. Findings included: Cross refer to tag F-880: Based on record reviews, observations, and staff and Nurse Practitioner (NP) interviews, the facility staff failed to disinfect a shared blood glucose meter (glucometer) between residents whose blood glucose levels required monitoring. Medication Aide (MA) #1 was observed to conduct a finger stick blood sugar (FSBS) check on Resident #1 and using the same glucometer proceeded to check blood sugar levels on Resident #2, Resident #3, and Resident #4 without disinfecting the glucometer between any of the residents. This occurred while there were no residents with known bloodborne pathogens, such as Hepatitis and Human Immunodeficiency Virus (HIV), in the facility. Failure to clean and disinfect the shared glucometer per manufacturer's instructions after use on each resident has the high likelihood of exposing residents to the spread of bloodborne pathogens. The deficient practice occurred for 4 of 4 residents observed for finger stick blood sugar monitoring. During an interview on 7/10/24 at 4:55 pm, MA #1 revealed she was not trained on cleaning and disinfecting glucometers per the manufacturer's instructions in the facility. She stated she had	F 726	disinfecting of glucometers per the manufacturers guidelines as deemed needed during orientation. The glucometers as of July 11, 2024, have been placed at bedside for the individual resident and labeled. Any resident admitted to the facility that needs a glucometer will have an audit tool conducted to monitor the need for the glucometer and placement of this device in their room and labeled for use. The Director of nursing or designee will visually audit (3) days a week on various shifts with nursing personnel ensuring glucometers are being cleaned before and after use with accuchecks x1 month, then will visually audit glucometers cleaning on various shifts x1 week for (2) two months. The Administrator will also review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	

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always wiped down her cart and the glucometer with 2 wipes. One wipe was used to clean and the other wipe to disinfect. She indicated nobody watched her perform the process of cleaning and disinfecting glucometers while she worked in the facility.

During an interview on 7/11/24 at 9:15 AM, the Staff Development Coordinator/Infection Preventionist (SDC/IP) revealed she just started her job three months ago and she was not sure what had been taught to the medication aides regarding cleaning and disinfecting the glucometers. She could not find orientation checklists for the MAs including MA #1 and was having to come up with her own orientation checklists which included cleaning and disinfecting glucometers. She said she did an in-service about infection control and disinfecting glucometers in April 2024 based on the facility's policy. She had staff sign rosters when doing an in service. She stated she was not sure if MA #1 attended the in-service. She was not able to provide a roster for the in-service in April 2024. The SDC/IP stated she was not sure if the medication aides' competencies were verified or how they were verified. She revealed she could not find the training folders. The SDC/IP stated in the future, she would ask the nurse and MA's to demonstrate the cleaning and disinfecting of glucometers per manufacturer's instruction to make sure they understood when she trained them.

After the interview on 7/11/24 with the SDC/IP, evidence of training and verification of competencies for cleaning and disinfecting glucometers for MA #1, MA #2, MA #3, MA #4 and MA #5 was requested from the SDC/IP. As of

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the survey's exit, no evidence was provided.

During an interview on 7/11/24 at 9:27 am, the Director of Nursing (DON) revealed she started her job in April 2024. The DON explained the MA not cleaning and disinfecting the glucometer between resident use was an example of not having a strong training and a good orientation program which she observed in the facility when she first got the job in April 2024. She could not find training folders, or the staff folders did not have records regarding training, such as infection control, in them. The DON stated they had an in service on checking blood glucose and the cleaning and disinfection of glucometers in April of 2024. She did not know if MA #1 was at the April in service. She could not find any evidence the nurses and the MAs' competencies were verified. She stated she hired the SDC/IP and trained her. She also hired two Unit Managers to help with training and educating staff. The DON was hoping to structure the orientation program and streamline the education. The constraint to the effective training program was the staffing shortage. She stated the SDC/IP and the Unit Managers who she was hoping to help train were getting pulled to work the carts. The DON stated she was trying to create processes and improve their training program and had made strides since she started.

On 7/11/24 at 10:03 am, an interview was conducted with the Administrator, in the presence of the DON. The Administrator revealed she just started at the facility in January 2024 as the administrator. She revealed there were a lot of improvements that needed to be made at the facility and she was working closely with the DON to ensure improvements were made.

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During an interview on 7/11/24 at 2:05 pm, the Regional Nurse Consultant stated the Chief Nursing Officer sent an email to the DON regarding the use of glucometers in April and the staff had the in-service on checking blood sugars and cleaning and disinfecting the glucometers. She revealed MA #1 told her on 7/11/24 that nobody in the facility trained her on the cleaning and disinfecting of glucometers in between residents per manufacturer's instructions.

The Administrator was notified of Immediate Jeopardy on 7/11/24 at 1:50 pm.

The facility provided the following credible allegation of Immediate Jeopardy removal.

"Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

On 7/10/2024 at 4:45 p.m., Medication Aide (MA) #1 performed a fingerstick blood glucose check on Resident #1, #2, #3, and #4. MA #1 failed to perform glucometer fingersticks on 4 residents utilizing each resident's personal glucometer and instead used one (1) glucometer for the 4 residents. MA #1 failed to cleanse and disinfect the glucometer according to glucometer manufacturer and EPA-registered disinfectant germicidal wipes recommendations. MA #1 did not follow the facility process and manufacturer and disinfected product guidelines despite having received proper training

"Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and

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when the action will be complete.

On 7/10/2024 at 5:10 p.m., The Medical Director was notified of the incident by the interdisciplinary team (IDT). The IDT discussed education and systems to put into place to prevent future staff competency issues related to blood glucose monitoring. These systems included education to MA #1, all nurses, and medication aides. On 7/10/2024, SDC #2 was notified by Nurse Consultant #1 of her responsibility to conduct education with nurses and medication aides regarding residents' personal glucometers for individual use, the proper steps to clean and disinfect a glucometer, storage of a glucometer, and where to locate a glucometer when needed. The education will be monitored by Staff Development Coordinator (SDC) #2 and included in all orientation process for newly hired nurses and medication aides.

On 7/10/2024 at 5:10 p.m. the IDT team reviewed the manufacturer instructions to obtain the manufacturer recommendations for glucose cleansing and disinfecting. The manual under section B read; Testing confirmed the following wipes will not damage the functionality or performance of the meter, this included germicidal disposable wipes (EPA 9480-4). The germicidal disposable wipes directions for use read: To disinfect nonporous surfaces use a wipe to remove visible soil prior to disinfecting. Unfold a clean wipe and thoroughly wet surface. Allow the surface to remain wet for two minutes. Let air dry.

On 7/10/2024 at 5:15 p.m., SDC #2 in-serviced Medication Aide (MA) #1 on the policy and procedure of cleaning and disinfecting

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glucometers, observed a return demonstration, and educated on potential consequences of not properly cleaning and disinfecting glucometers. The education included the manufacture guidelines for the glucometer and the germicidal wipe recommendations to clean and then disinfect with two minutes of wet contact time. The SDC then in-serviced all nurses and medication aides working. SDC then began in-servicing all nurses and medication aides not currently working at the facility. All staff were instructed to see the Director of Nursing (DON) and/or SDC before their next shift for a return demonstration. The SDC will educate all newly hired nurses, medication aides and agency staff before receiving an assignment. The SDC will be responsible for keeping up with the newly hired staff and new agency staff. The new staff will be in-serviced on glucometer disinfection prior to working on a medication cart and will be required to perform a return demonstration for the DON or SDC before the next assignment.

The glucometer policy was placed on every medication cart and reads:
1. Obtain needed equipment and supplies: Gloves, glucometer, alcohol pads, gauze pads, single-use lancet, blood glucose testing strips, disinfecting wipes.
2. Perform Hand Hygiene.
3. Explain the procedure to the resident.
4. Provide privacy.
5. Don gloves.
6. Obtain capillary blood glucose sampling.
7. Remove and discard gloves, perform hand hygiene prior to exiting the room.
8. Retrieve (2) disinfectant wipes from container.
9. Using the first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the

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surface of the glucometer.
10. After cleaning, use the second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, according to the glucometer manufacturer's instructions. Follow the germicidal directions for the dry time. Allow the glucometer to air dry.
11. Discard disinfectant wipes in waste receptacle.
12. Perform hand hygiene.

On 7/11/2024 the IDT made the decision to move all resident glucometers into the corresponding resident's room to be stored at the bedside. The glucometers were moved by the Unit Managers on 7/11/2024 and education on the location of the glucometers was provided to all nurses and Medication Aides working on this shift. Any nurse, medication aide, or agency staff that were not working on 7/11/2024 will receive education prior to starting the next scheduled shift. This education will be conducted by SDC #2.

Alleged date of Immediate Jeopardy removal is 7/12/24.

The credible allegation for immediate jeopardy removal was validated on 07/17/24. Education for nurses and medication aides was confirmed as completed. The education included obtaining capillary blood glucose sampling and cleaning/disinfecting glucometers per the manufacturer's instructions before and after each resident or to use individual glucometers. Review of the facility audits revealed nurses and medication aides had been observed by Director of Nursing (DON), and Staff Development Coordinator (SDC) performing blood checks and cleaning/disinfecting the glucometers. The audits

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F 726	Continued From page 18 documented there were no issues. During this survey both licensed nurses and medication aides were interviewed and revealed knowledge of education and training to show competency to provide care and disinfect residents' glucometers and knowledge that all residents have their personal glucometers in their rooms. Education for licensed nurses and unlicensed staff was confirmed with observations of staff providing glucose blood checks on each hall and the glucometers were cleaned/disinfected with no issues identified during this survey. The immediate jeopardy removal date of 07/12/24 was validated.	F 726		
F 761 SS=E	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	F 761		8/1/24

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F 761	Continued From page 19 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 record review, observations, and staff, Pharmacist and Nurse Practitioner (NP) interviews, the facility failed to send expired or discontinued narcotic medications back to the pharmacy for 2 of 4 medication carts. Findings included: 1. On 7/10/24 at 11:45 am, the medication cart on 2 North was reviewed with Medication Aide (MA) #2. The following were discovered during the review: a. Eighteen lorazepam 0.5 mg tablets in a pill card labeled with the order to administer one tablet by mouth twice a day for anxiety or restlessness to Resident #7. Thirty lorazepam 0.5 mg tablets were in a second pill card labeled with the same order to administer one tablet by mouth twice a day for anxiety or restlessness to Resident #7. Resident's EMR was reviewed with MA #2. The medical records revealed Resident #7 died on 6/14/24. MA #2 stated the two pill cards should have been sent back to the pharmacy by the nurse on 6/14/24. b. Twenty oxycodone-acetaminophen 5-325 mg tablets in a pill card labeled with the order to	F 761	F761 Unit Managers audited the medication carts for expired or unlabeled medications on July 10th and 11th. This audit included checking to see if medications were stored in accordance with manufacturers recommendations. Any issues identified were remedied. Nurses and medication aides were educated on proper labeling of medications in the cart to include name of resident, discarding expired medications, discarding single use vials after initial use, and storage. This education was provided by the Staff Development Coordinator, Director of Nursing and Unit Managers. Any nurse or med aide that did not receive the education by July 31, 2024, will not be able to work until the education is complete. Newly hired nurses and medication aides will receive education in orientation from the Staff Development Coordinator or Director of Nursing in her absence The Unit Managers or designee will conduct an audit twice a week for twelve weeks of each medication cart to ensure that there are no expired medications on the cart. This audit will also include proper labeling to include name of resident, discarding single use vials after initial use, and storage according to	

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F 761	Continued From page 20 administer one tablet every four hours as needed to Resident #8. The pill card was delivered on 7/8/23 and was labeled to discard after 7/6/24. Review of Resident #8's EMR was reviewed with MA #2. Resident #8 did not have a current order for the narcotic medication. The medication was discontinued on 9/19/23. Review of the narcotic sheet did not indicate Resident #8 received any of the expired medication. MA #2 stated the nurse should have sent the pill card back to the pharmacy when the medication was discontinued on 9/19/23. c. Nine tablets of alprazolam 0.25 mg tablets in a pill card labeled with the order to administer one tablet once a day as needed for anxiety for Resident #9. The pill card was delivered on 5/15/23 and was labeled to discard after 5/14/24. Review of Resident #9's EMR with MA #2 revealed no current order for alprazolam. The medication was discontinued on 5/29/23. Review of the narcotic sheet indicated no expired medication was administered to Resident #9. d. Twenty-eight tramadol hydrochloride (hcl) 50 mg tablets in a pill card labeled with the order to administer one tablet by mouth every six hours as needed for moderate and severe pain for Resident #10. The pill card was delivered on 6/30/23 and was labeled to discard after 6/27/24. Review of Resident #10's EMR with MA #2 revealed no active order for tramadol. Review of the narcotic sheet indicated no expired medication was administered to Resident #10. During an interview on 7/10/24 at 11:50 am, MA	F 761	manufacturer's recommendations. The Administrator will also review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	

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#2 stated the nurses were supposed to check their medication carts for expired medications and send them to the pharmacy to be discarded. She was not sure how often they were supposed to do it.

2. On 7/10/24 at 12:20 pm, the medication cart on 2 East was reviewed with MA #3.

The following was discovered during the review:

a. One tramadol hcl 50 mg tablet in a pill card labeled with the order to administer one tablet every six hours as needed for pain to Resident #11. The pill card was delivered on 6/7/23 and labeled to discard after 6/3/24.
Review of Resident #11's EMR with MA #3 revealed a current order for the medication.
Review of the narcotic sheet indicated Resident #11 did not receive any of the expired medication.
MA #3 stated the nurse should have checked the cart and sent expired narcotics to the pharmacy.

b. One tramadol hcl 50 mg tablet in a pill card labeled with the order to administer one tablet every six hours as needed for moderate to severe pain to Resident #12. The pill card was delivered on 5/30/23 and labeled to discard on 5/26/24.
Review of Resident #12's EMR with MA #3 revealed a current order for the medication.
Review of the narcotic sheet indicated Resident #12 received eight expired medications on 6/5/24, 6/17/24, 6/18/24, 6/19/24, 6/20/24, 6/22/24, 6/24/24, and 6/29/24.

c. Eight hydrocodone acetaminophen 5-325 mg tablet in a pill card labeled with the order to administer one tablet by mouth every six hours as needed for pain to Resident #13. The pill card

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was delivered on 4/11/23 and labeled to discard on 4/5/24.

Review of Resident #13's EMR with MA #3 revealed a current order for the medication. Review of the narcotic sheet indicated Resident #13 received two expired medications on 4/14/24 and 5/4/24.

During an interview on 7/10/24 at 12:25 pm, MA #3 stated the nurses were supposed to be checking their medication carts. She revealed the day shift nurse who used to check the carts had been gone for a while and nobody was checking on the carts. She stated two nurses had to count off if a narcotic had to be sent back to the pharmacy. They scanned the narcotic code into the pharmacy system, entered the amount, and put the narcotic medications in a paper bag with the narcotic sheet and taped the bag. The nurse put the taped bag in a red box inside the medication room for the pharmacy to pick up.

During an interview on 7/10/24 at 12:15 pm, Nurse #1 stated she monitored the medication aides on the second floor. The nurses and unit managers checked the medication carts for expiration dates routinely. She said they do not have set dates or days to check the carts. It varied. She could not remember the date the last time she checked the carts. She revealed the pharmacy also came and checked the carts to do their audit for the medication stocks.

During an interview on 7/10/24 at 2:00 pm, Unit Manager #1 revealed the nurses should be checking the medication carts and pull out the expired or discontinued medications and send them back to the pharmacy. Third shift nurses

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were supposed to be checking for expiration dates in the medication room and the carts every night. All the nurses and medication aides were supposed to check the medication rooms.

During an interview on 7/11/24 at 9:15 AM the Staff Development Coordinator (SDC) revealed she had been in that position for three months. She stated all the nurses and MAs should be checking for expiration dates before they did their medication pass.

During an interview on 7/11/24 at 12:35 pm, the Pharmacist stated that nursing staff should have sent the expired medication back to the pharmacy so they could be discarded. There may not be side effects on the residents that received the expired medication. However, the Pharmacist revealed there were some drugs that were time sensitive especially if the medications were repacked and heat sealed. The pill cards were repacked and were heat sealed so the facility had to discard those medications right after the expiration date. That was the best practice.

During an interview on 7/11/24 at 9:43 am, NP #2 stated if a narcotic medication expired and it was administered close to that date, it should not have any side effects on the residents. The expiration dates were more of an approximation or suggestion, but the nursing standard was not to administer any kind of medications after the expiration date.

During an interview on 7/11/24 at 9:27 am, the Director of Nursing (DON) revealed she started her job in the facility in April. The nurses and MA's should be checking for medication expiration dates all the time. If a medication was

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F 761	Continued From page 24 discontinued or if a resident got discharged, the medications should be sent back to the pharmacy. During an interview on 7/11/24 at 10:03 am, the Administrator stated she started her job in January. She revealed that there were a lot of things that needed to improve in the facility including medication storage. The nursing staff working on the carts should be checking for expiration dates before their medication administration. The Administrator said she would continue working with the DON in improving the facility. She stated she expected staff to follow policies and procedures accordingly.	F 761		
F 880 SS=K	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 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §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: §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	F 880		8/1/24

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conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(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.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

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F 880	Continued From page 27 for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training. The findings included: A review of the facility's policy entitled "Glucometer Disinfection" last revised 12/1/23 read in part as follows: "1. The facility will ensure glucometers will be cleaned and disinfected according to manufacturer's instruction for multi-resident use ... 3. The glucometers will be disinfected with a wipe pre-saturated with an Environmental Protection Agency (EPA) registered healthcare disinfectant that is effective against HIV, Hepatitis C, and Hepatitis B virus. 4. Glucometers will be cleaned and disinfected according to manufacturer's instructions regardless of whether they are intended for single resident or multiple resident use." The manufacturer's User Guide for cleaning and disinfecting the glucometer read in part, "Blood glucose meters are at high risk for becoming contaminated with bloodborne pathogens such as Hepatitis B Virus (HBV), Hepatitis C Virus (HCV) and Human Immunodeficiency Virus (HIV). Transmission of these viruses has been documented due to a contaminated blood glucose device. According to the Centers for Disease Control and Prevention, cleaning and disinfecting of meters between resident use can prevent the transmission of these viruses through indirect contact ...Blood glucose meters need to be cleaned and disinfected after each use for individual resident care ... Disinfecting can be accomplished with an EPA registered disinfectant	F 880	11, 2024. Education was provided to licensed nurses and/or medication aides on the cleaning and disinfecting of glucometers per manufacturer guidelines with proper EPA disinfectant by July 12, 2024. Any new hires entering the facility will receive education on the cleaning and disinfecting of glucometers per the manufacturers guidelines as deemed needed during orientation. The glucometers as of July 11, 2024, have been placed at bedside for the individual resident and labeled. Any resident admitted to the facility that needs a glucometer will have an audit tool conducted to monitor the need for the glucometer and placement of this device in their room and labeled for use. The Director of nursing or designee will visually audit (3) days a week on various shifts with nursing personnel ensuring glucometers are being cleaned before and after use with accuchecks x1 month, then will visually audit glucometers cleaning on various shifts x1 week for (2) two months. The Administrator will also review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	

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detergent or germicide that is approved for healthcare settings..."

On 7/10/24 from 4:45 pm through 4:55 pm, a continuous observation of MA #1 performing FSBS on the 1 North unit was conducted. At 4:45 pm, MA #1 put on gloves and obtained the glucometer from a compartment in the top drawer of her medication cart. She completed a FSBS check on Resident #1 and using the same glucometer proceeded to check blood sugar levels on Resident #2, Resident #3, and Resident #4 without disinfecting the glucometer between any of the residents. In between each resident, the MA returned to the cart to change gloves and use hand sanitizer. At 4:55 pm, the MA was observed to place the glucometer back in the compartment of the top drawer after checking Resident #4's blood sugar without cleaning and disinfecting the glucometer.

During an interview on 7/10/24 at 4:55 pm, MA #1 revealed she cleaned the glucometer with disinfectant wipes when she started her shift (MA #1 worked 7:00 am to 7:00 pm according to the schedule on 7/10/24). The MA explained she wiped down her cart and the glucometer when she came in with two disinfecting wipes each time, one was to clean, and the other was to disinfect. The MA said she then wiped down the cart again including the glucometer before the end of her shift. The MA said she had worked at the current facility for about 2 years but, she was trained by another medication aide at another facility years ago to wipe down the cart and the glucometer at the start and end of each shift. She stated not every resident had their own glucometer. MA #1 explained she did not clean and disinfect glucometer in between residents;

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she just cleaned and disinfected the glucometer before and after her shift with disinfectant wipes. MA #1 stated the glucometer was not technically touching the resident and she made sure she did not put the glucometer down in the resident's room. The MA said there was a 5th resident who she would have completed a FSBS check on, but the resident was at dialysis.

An observation of 1 North medication cart and interview of MA #1 was conducted on 7/11/24 at 10:00 am. There were five individual bags containing glucometers labeled with residents' names, including Resident #1, Resident #2, Resident #3, Resident #4, and the dialysis resident that were seen at the bottom drawer of the medication cart. There was a plastic container with a purple top containing disinfectant wipes inside another bottom drawer. Medication Aide #1 stated she did not see the residents' individual glucometers on 7/10/24. She further stated she used the disinfecting wipes in the purple top container to wipe down the glucometer and her cart at the start and end of her shift. The observed disinfectant wipes brand was listed as one of the accepted disinfectant wipes from the glucometer manufacturer.

Review of the purple top container containing the disinfectant wipes label indicated it contained germicidal disposable wipes effective against bacteria, viruses, fungi, and blood borne pathogens when used as directed. The label specified blood borne pathogens such as Hepatitis B Virus, Hepatitis C Virus, and HIV among others.

Attempts to interview the Unit Manager, who was supervising MA #1, for 1 North during the survey

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were unsuccessful.

During an interview on 7/11/24 at 9:15 AM, the Staff Development Coordinator/Infection Preventionist (SDC/IP) revealed the facility used disinfecting wipes in a purple top plastic container. The staff used the first wipe to clean the glucometer and used the second wipe to disinfect. The staff had to wait for the disinfectant to dry for about 5 to 6 minutes and then the glucometer could be used on another resident or put them back in the individual bags if they were done checking blood sugars.

During an interview on 7/16/24 at 10:55 am, NP #1 revealed she was made aware on 7/11/24 by the facility about the glucometer not being cleaned and disinfected in between residents on 7/10/24. The NP said the cleaning and disinfecting of the glucometer was to prevent the transmission of blood borne pathogens to the residents. She stated that was the standard and staff had to follow it.

During an interview on 7/11/24 at 9:27 am, the Director of Nursing (DON) revealed the facility had individual glucometers for residents needing to have their blood glucose monitored. She stated MA #1 was not familiar with the 1 North medication cart. She revealed she spoke with MA #1 this morning and informed her the glucometers for individual residents were at the bottom of the cart. The DON said the MAs and the nursing staff should be cleaning and disinfecting the glucometers before and after each use on each resident using the disinfectant wipes as per their policy for disinfecting glucometers.

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On 7/11/24 at 10:03 am, an interview was conducted with the Administrator, in the presence of DON. The Administrator revealed she just started at the facility in January as the administrator. The MA should have cleaned and disinfected the glucometer in between the residents. MA #1 should have used the resident's individual glucometer. She stated they expected staff to follow their policies and procedures.

During a discussion on 7/11/24 at 2:05 pm, the Regional Nurse Consultant stated MA #1 should have cleaned and disinfected the glucometer in between residents according to the facility's policy and manufacturer's instructions.

The Administrator was informed of the Immediate Jeopardy on 7/11/24 at 12:34 pm.

The facility provided the following credible allegation of Immediate Jeopardy removal.

"Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

On 7/10/2024 at 4:45 p.m., Medication Aide (MA) #1 performed a fingerstick blood glucose check on Resident #1, #2, #3, and #4. The MA removed a glucometer for a recently discharged resident (Resident #5) from the medication cart. The MA did not cleanse or disinfect the glucometer, according to glucometer's manufacturer's instructions and germicidal wipe manufacturer's instructions, prior to testing, between each resident, or upon completion. All residents that required blood glucose monitoring were identified on the 7/10/2024 census and added to the potentially affected resident list. No residents that

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receive glucometer blood glucose monitoring were identified to have blood borne pathogens.

"Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 7/10/2024 at 5:10 p.m., The Medical Director was notified of the incident by the interdisciplinary team (IDT). The IDT discussed education and systems to put into place to prevent future staff competency issues related to blood glucose monitoring. These systems included education to MA #1, all nurses, and medication aides. The education will be monitored by Staff Development Coordinator (SDC) #2 and included in all orientation to newly hired nurses and medication aides.

On 7/10/2024 at 5:10 p.m. the IDT team reviewed the manufacturer's recommendations for glucose cleansing and disinfecting. The manual under section B read; Testing confirmed the following wipes will not damage the functionality or performance of the meter, this included suggested manufacturer germicidal disposable wipes. The germicidal disposable wipes directions for use read: To disinfect nonporous surfaces use a wipe to remove visible soil prior to disinfecting. Unfold a clean wipe and thoroughly wet surface. Allow the surface to remain wet for two minutes. Let it air dry.

On 7/10/2024 at 5:15 p.m., SDC #2 in-serviced Medication Aide (MA) #1 on the policy and procedure of cleaning and disinfecting glucometers, observed a return demonstration, and educated on potential consequences of not

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properly cleaning and disinfecting glucometers. The education included the manufacture guidelines for the glucometer and the germicidal wipe recommendations to clean and then disinfect with two minutes of wet contact time. SDC then in-serviced all nurses and medication aides working. SDC then began in-servicing all nurses and medication aides not currently working at the facility on the telephone. All nursing staff and medication aides were instructed to see the Director of Nursing (DON) and/or SDC before their next shift for a return demonstration of blood glucose monitoring cleansing and disinfection process. The SDC will educate all newly hired nurses, medication aides and agency staff regarding cleaning and disinfection of glucometers, before receiving an assignment. On 7/10/2024, SDC #2 was notified by Nurse Consultant #1 of her responsibility to conduct education with nurses and medications aides regarding resident's personal glucometer for individual use, the proper steps to clean and disinfect a glucometer, storage of a glucometer, and where to locate a glucometer when needed. The SDC will be responsible for keeping up with the newly hired staff and new agency staff. The new staff will be in-serviced on glucometer disinfection prior to working on a medication cart and will be required to perform a return demonstration for the DON or SDC before the next assignment.

On 7/10/2024 at 5:15 p.m. the Unit Manager removed the glucometer of the discharged Resident (Resident #5) and discarded the glucometer.

On 7/10/2024 the Director of Nursing and Unit Manager assessed, cleansed, and disinfected all

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glucometers according to the manufacturer recommendations for glucose disinfection and the germicidal disposable wipes directions.

On 7/10/2024, an audit was conducted by Nurse Consultant #1 and Unit Manager to verify that residents had personal glucometers on the medication carts, bagged, and labeled. The audit revealed 100% of residents that required glucose monitoring had individualized glucometers available.

The Administrator notified Guilford County Department of Health of the incident on 7/11/2024. The Health Department had no initial recommendations but requested a summary of the event. The Health Department responded to the summary with recommendations to conduct laboratory blood work on all diabetics that receive blood glucose monitoring to screen for blood borne pathogens. Medical Director was notified on 7/11/2024 of Guilford County Department of Health recommendations. On 7/11/2024, the physician orders were entered into the laboratory system by the DON or designee. The DON will be responsible for ensuring orders are implemented, the laboratory order is completed, and communicate results to the health department and Medical Director.

The glucometer policy was placed on every medication cart by the Assistant Nursing Home Administrator on 7/10/2024 and reads:
1. Obtain needed equipment and supplies: Gloves, glucometer, alcohol pads, gauze pads, single-use lancet, blood glucose testing strips, disinfecting wipes.
2. Perform Hand Hygiene.
3. Explain the procedure to the resident.

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4. Provide privacy.
5. Don gloves.
6. Obtain capillary blood glucose sampling.
7. Remove and discard gloves, perform hand hygiene prior to exiting the room.
8. Retrieve (2) disinfectant wipes from container.
9. Using the first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer.
10. After cleaning, use the second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, according to the glucometer manufacturer's instructions. Follow the germicidal directions for the dry time. Allow the glucometer to air dry.
11. Discard disinfectant wipes in waste receptacle.
12. Perform hand hygiene.

On 7/11/2024 the IDT team made the decision to move the glucometers off the medication carts and into each resident's room. Education was provided by the Unit Managers to all Nurses and Medication Aides working on 7/11/2024 regarding the location of the glucometers in the rooms and this education will be provided to all nursing and MA staff prior to working the next shift, by the SDC. Any nurse or medication aide found to be sharing glucometers will be subject to disciplinary action.

The alleged date of Immediate Jeopardy removal was 7/12//24.

The facility's credible allegation of immediate jeopardy removal was validated on 7/17/24. Documentation of the County Health Department, physician, and residents' Responsible Party notification was provided and reviewed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345116	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT HILLS CENTER FOR NURSING AND REHAB	109 S HOLDEN RD GREENSBORO, NC 27407

(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	Continued From page 36 Evidenced by observations of nurses and medication aides and interviews conducted on each hallway with regards to the required infection control practices for the use of glucometers. All nurses and medication aides who were interviewed reported they had received the required in-service training. This training included the importance of using an approved disinfectant wipe and disinfecting a glucometer with the procedures in accordance with the manufacturer's instructions for the disinfectant. Observations were conducted on each hallway as blood glucose checks were conducted and glucometers were disinfected. All residents observed had their own personal glucometers. Multiple observations also confirmed EPA-approved disinfectant wipes were stored on each medication cart. The immediate jeopardy removal date of 07/12/24 was validated.	F 880		