STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345413	A. BUILDING _____ B. WING _____	C 09/06/2024

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FLESHERS FAIRVIEW HEALTH CARE	3016 CANE CREEK ROAD FAIRVIEW, NC 28730

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 09/03/24 through 09/06/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# YVCU11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 09/03/24 through 09/06/24. Event ID# YVCU11. The following intakes were investigated: NC00206386 and NC00214180. One (1) of the 5 complaint allegations resulted in deficiency.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those	F 582		9/17/24

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

Electronically Signed | 09/25/2024

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F 582	Continued From page 1 services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a completed Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) prior to discharge from Medicare Part A skilled services to 1 of 3 residents (Resident #45) reviewed for beneficiary notification. The findings included:	F 582	The responsible party for resident identified as not being provided a completed Skilled Nursing Facility Advanced Beneficiary Notice prior to discharge from Medicare Part A skilled services was issued a SNFABN on 9/10/24 by the Business Office Manager.	

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F 582	Continued From page 2 Resident #45 was admitted to the facility on 1/27/24 with diagnoses that included non-traumatic brain dysfunction, Alzheimer's disease and dementia. The most recent quarterly Minimum Data Set assessment dated 8/2/24 indicated Resident #45 was severely cognitively impaired. A review of the medical record revealed a Notice of Medicare Non-Coverage (NOMNC) was provided to and discussed with Resident #45's resident representative on 4/4/24 which indicated Resident #45's Medicare Part A coverage for skilled services would end on 4/12/24. Resident #45's Medicare Part A coverage started on 1/28/24, and Resident #45 had 23 days remaining. Resident #45 remained in the facility even after her Part A coverage ended on 4/12/24. A review of Resident #45's medical record revealed no evidence a SNF-ABN was provided to Resident #45. An interview with the Business Office Manager on 9/5/24 at 2:31 PM revealed Resident #45 had used 77 days of her Medicare Part A days and had 23 days remaining, but she didn't issue a SNF-ABN because she thought it was only used for managed care residents. She explained that she had only been issuing a NOMNC to residents who were discharged from Medicare Part A or Medicare Part B but remained at the facility because this was how she was trained. She stated the skilled need was for physical therapy and speech therapy and both services were discontinued on 4/12/24.	F 582	Business Office Manager reviewed all resident records that would have had the potential to be affected by not being provided a completed SNFABN and none were found. Education was provided to both the Business Office Manager and Assistant on 9/16/24 by Jennifer Kime Assistant Administrator regarding Medicare guidelines, and in which instance to issue an ABN or SNFABN along with NOMAC notifications to beneficiaries. Assistant Administrator or designee will monitor and evaluate any residents being discharged from Medicare Part A skilled services to ensure compliance is met. Monitoring will continue until compliance is maintained for 1 month or longer if the QAPI committee recommends it. Completion date: 09/17/24	

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F 582	Continued From page 3 An interview with the Assistant Administrator on 9/6/24 at 10:29 AM revealed that she was aware that a SNF-ABN form should also be issued for residents who got discharged from Medicare Part A services but remained at the facility. She stated that they could rectify what the Business Office Manager had missed.	F 582		
F 583 SS=B	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.	F 583		9/30/24

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F 583	Continued From page 4 (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain the privacy of a resident's record when the computer screen was left open with resident information exposed during 2 observations for 1 of 4 medication carts observed (600-hall medication cart). Findings included: During an observation on 9/3/24 at 12:32 PM the 600-hall medication cart was observed unattended. The computer screen was open and displayed a resident's Medication Administration Record (MAR). The screen displayed the resident picture, name, date of birth, room number, record number, special instructions, allergies, current vital signs, and medications. Staff were observed on the hallway passing out lunch trays. Nurse #1 returned to the medication cart at 12:36 PM and placed the privacy screen on the computer before she left the hall. On 9/3/24 at 12:42 PM Nurse #1 was observed as she returned to the 600-hall medication cart. Nurse #1 left the medication cart at 12:43 PM and entered a resident's room. The 600-hall medication cart computer screen was observed open and displayed a resident's MAR. The screen displayed the resident picture, name, date of birth, room number, record number, special instructions, allergies, current vital signs, and medications. Nurse #1 returned to the 600-hall	F 583	On 9/6/24 after becoming aware of the computer screen being left open without the privacy screen covering it, the DON immediately went to nurse and instructed her on the importance of always having screen covered with privacy screen when it is unattended. DON checked the other screens and they were all found to have the privacy screen up. DON then spoke with the rest of the nurses to ensure their screens were covered when unattended to ensure privacy. Other residents may have the potential to of privacy not being protected if computer screen is not covered with a privacy screen when a computer is unattended. Education has been ongoing by the facility Staff Development Coordinator to reach all nursing staff on various shifts on the importance of having the privacy screen on computers when the computer is unattended. In-services started on 9/23/24 and will be completed with all nursing staff by 9/29/24. All nurses are being required to additionally read through the in-service material online through Paycom and sign that they have reviewed it. DON or designee will monitor for compliance of use of privacy screens	

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F 583	Continued From page 5 medication cart at 12:46 PM. On 9/3/24 at 12:47 PM an interview was conducted with Nurse #1. She said that the privacy screen for the medication cart computer was supposed to be on when a nurse was not at the cart. Nurse #1 said she should have put the privacy screen up before she left the medication cart but had forgotten. An interview was conducted on 9/3/24 at 9:32 AM with the Director of Nursing (DON). The DON said that Nurse #1 should have put the privacy screen on before she walked away from the medication cart. The DON said the privacy screen should be turned on when the nurse left the cart to protect resident information. An interview was conducted with the Assistant Administrator on 9/3/24 at 10:22 AM. She said that Nurse #1 should have put the privacy screen on when she left the medication cart to keep someone who was walking by from seeing resident information.	F 583	when computers are not in use 5x per week for 4 weeks or longer if the QAPI committee recommends it. Completion date: 9/30/24	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, interviews with the	F 689	Resident who was identified as having a	9/30/24

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F 689	Continued From page 6 Medical Director (MD), resident and staff, the facility failed to provide care in a safe manner when a resident fell from her bed during personal care. Resident #4 fell off her bed striking a chair positioned next to the bed and subsequently fell to the floor that resulted in severe acute pain that required STAT (now) morphine and a fractured right femur. The resident was hospitalized for surgical repair of the fractured femur. This was for 1 of 5 residents reviewed for the prevention of accidents (Resident #4). Findings Included: Resident # 4 was admitted to the facility on 6/10/23 with diagnosis that included functional quadriplegia, dementia, and traumatic brain injury. A review of Resident #4's care plan updated 3/26/24 found she was care planned for being at risk for falls related to functional quadriplegia, hemiplegia, chronic pain, and TBI. Interventions included maintaining the resident's environment free of clutter and safety hazards, maintain bed in low and locked position, M-rails (half rails) to both sides of the bed for mobility and transfers. A review of the annual Minimal Data Set (MDS) dated 6/27/24 coded Resident #4 with intact cognition intact and dependent on staff for bathing, dressing, and personal hygiene. She required maximum assistance with rolling left and right, required a 2 person lift for transfers, and a wheelchair for mobility. The resident was not coded for rejection of care during the 7-day lookback period. Nursing Aide (NA #2) who was performing	F 689	fall that resulted in right femur fracture was sent to the ER on 7/16/24. She was admitted to the hospital for surgical repair of her femur and was discharged back to facility on 7/21/24. In-service training was provided by the DON with all direct care staff immediately after resident was transported to the ER on 7/16/24. In-service training included proper step by step procedure of providing a bed bath and steps to take if a resident becomes combative during care. Including getting resident into a safe position and getting additional staff for assistance. Residents plan of care was reviewed and insured fall interventions were in place. Care plan updated to include having additional staff members present during care if resident is combative. Other residents could have the potential to be affected if a resident becomes combative or resistant to care during care tasks. Other residents plan of care have been reviewed and ensured measures are appropriate and in place. Staffing schedules also reviewed to ensure consistent staff as much as possible. Education has been ongoing to reach all CNA's and nurses by the facility Staff Development Coordinator on various shifts on the steps to take if a resident becomes combative during care. In-Service education began on 9/23/24 and will be completed with all CNA's by 9/29/24. All CNA's are being required to additionally read through the in-service material online through Paycom and sign	

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F 689	Continued From page 7 Resident #4's bed bath on 7/16/24 was interviewed on 9/4/24 at 2:42 PM. NA #2 stated she was giving Resident #4 a bed bath after breakfast, was the only NA in the room and was close to being finished with the bed bath when the resident fell off the bed. NA #2 stated prior to beginning the bed bath with Resident #4, the resident was having behaviors and tried to hit her when NA #2 told her she needed to have a bed bath. NA #2 said that Resident #4 had received a bed bath the previous 2 days because she was soiled, and she was not happy she needed another one. NA #2 stated she continued with the bed bath because yelling and attempting to hit behavior was normal for Resident #4. NA#2 said Resident #4 was laying on her left side and was holding onto the bed railing with her right hand. Resident #4 had her right leg bent at an angle above her left leg. NA #2 told Resident #4 to not lower her right leg towards the edge of the bed, that she might fall off the bed. NA #2 stated Resident #4 lowered her right leg that caused the resident to fall off the bed, hitting a chair with her body that was sitting beside the bed and then to the floor. Resident #4 was screaming and yelling when she hit the floor, and NA#2 went to the hallway and called out for Nurse #2 to come to the room. A follow-up interview with NA #2 was conducted on 9/5/24 at 1:46 PM. NA #2 stated Resident #4 was laying on her left side, and she left Resident#4 laying on her side when she went to the sink to rinse out a washcloth. NA#2 stated she was on her way back to the bedside and was near the foot of the resident's bed when Resident #4 lowered her right leg and fell from the bed. NA #2 said she tried to stop Resident #4 from falling and was not able to grip her because the resident	F 689	that they have reviewed it. DON or designee will audit resident records to identify residents that become combative during care and observe these residents while direct care staff are preforming care. This will occur 3x per week for 4 weeks or longer if the QAPI committee recommends it. Completion date: 9/30/24	

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F 689	Continued From page 8	F 689		

was still wet.

The fall incident report dated 7/16/24 at 9:30 AM and completed by Nurse #2 was reviewed. The incident report read Nurse #2 was called to Resident #4's room by Nurse Aide (NA)#2, who stated Resident #4 was on the floor. Resident #2 was resisting care and rolled out of bed. The immediate action taken by Nurse #2 read in part: she tried to assess Resident #4 for injuries, but was unable and the resident kept screaming "help me" and "my leg hurts". The Director of Nursing (DON) came to calm down the resident. The MD was in the building and saw Resident #4 and ordered her to be sent to the ER for evaluation.

Nurse #2 was interviewed on 9/4/24 at 3:24 PM and stated she was working on 7/16/24 as Resident #4's assigned nurse. Nurse #2 stated NA #2 called for her, and said Resident #4 had fallen out of bed. Nurse #2 said Resident #4 could be heard screaming and yelling in the hallway before she arrived at the Resident's room. Resident #4 was laying on her back, almost flat. Nurse #2 said she tried to assess Resident #4 for injuries and Resident #4 would not allow her to touch her. Resident #4 was screaming her leg hurt. NA#2 told her that the resident had fell off the bed and bounced off the chair prior to hitting the floor. Nurse #2 stated she notified the DON and the MD who was in the building. The MD arrived to the room and ordered one does of pain and anxiety medication and 911 was then called to send Resident #4 to the ER for evaluation.

A review of physician's order dated 7/16/24 found an order for morphine 10 mg (milligrams) once

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F 689	Continued From page 9	F 689		

and Ativan 1 mg once for pain and anxiety.

A review of Resident #4's July 2024 medication administration record (MAR) for 7/16/24 found a one time dose of morphine 10 mg and one time dose of Ativan 1 mg was given as ordered.

A review of Nurse #2 nursing progress notes dated 7/16/24 read in part: During a bed bath, Resident #4 was resistant to care and pushed herself out of the bed to the floor. The resident was screaming, and Nurse #2 couldn't assess her injuries. The MD was at the facility and said to send Resident #4 out to the hospital, due to a possible breakage to her right hip/leg. The MD ordered a 1-time dose of pain medicine and anxiety medicine to help calm the resident. Resident #4 had been screaming and was resistant to anyone trying to assess her injuries. Emergency medical services (EMS) was notified, and she was sent to the emergency room (ER) for further eval.

A MD progress note dated 7/16/24 read in part: During hands on bathing care, Resident #4 resisted and pushed away causing her to fall landing on the floor and she avoided head injury. She was in acute pain, anxious and distressed. Resident #4 was unable to move without assistance and is intolerant to range of motion without extreme pain. A STAT order for Morphine 10 mg and Ativan 1 mg once and triage to the nearest ER for further care.

The hospital discharge report dated 7/20/24 was reviewed. The discharge report summary read in part: Resident #4 was admitted on 7/16/24 and found to have a fractured right intertrochanteric femur and performed surgical repair of the

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F 689	Continued From page 10	F 689		

fractured femur. The resident was discharged to the facility with a follow-up appointment with orthopedist in 2 weeks. The resident was discharged with medication orders of ibuprofen 600 mg every 6 hours as needed for pain, oxycodone 5 mg every 6 hours as needed for pain.

Resident #4 was interviewed on 9/3/24 at 11:00 AM in her room. She stated she had a fall from her bed and had broken her leg but was not able to provide details of the incident.

The MD stated on 9/5/24 at 10:44 AM Nurse #2 went to him and told him Resident #4 had fallen. The MD stated Resident #4 was found on the floor beside her bed laying on her back when he arrived at the room. The resident was screaming in pain and would not allow an injury assessment. The MD said he ordered STAT pain medication and anxiety medication and had Resident #4 sent to the ER. The hospital found Resident #4 had sustained a broken right femur and required surgery. The MD was unaware of the details of Resident #4's fall, but recalled she was resisting care and fell out of her bed.

The DON stated on 9/05/24 at 3:21 PM she was called down to Resident #4's room for a fall on 7/16/24. The MD, Nurse #2, and NA#2 were in the room and she observed Resident #4 laying on the floor and screaming in pain. The MD had ordered pain and anxiety medications for her and then ordered Resident #4 to be sent to the ER. The DON said she interviewed NA #2 about the incident and NA #2 said she was providing a bed bath to Resident #4 who was soiled that morning (7/16/24). NA #2 said Resident #4 had received a couple bed baths already that week and

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F 689	Continued From page 11 Resident #4 was not happy she needed another bed bath. NA #2 reported she had Resident #4 laying on her left side and was almost done with the bed bath. NA #2went to rinse out the washcloth at the sink and left Resident #4 laying on her side near the edge of the bed. Resident #4 shifted her right leg and fell off the bed hitting the chair beside the bed and then onto the floor. NA #2 was near the sink, and unable to prevent Resident #4 from falling. The DON stated NA #2 should not have left Resident #4 on her side, close to the edge of the bed when she left the bedside.	F 689		
F 726 SS=E	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 limited to assessing, evaluating, planning and implementing resident care plans and responding	F 726		9/30/24

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F 726	Continued From page 12 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, and staff interviews the facility failed to provide competent nursing staff when 5 of 6 nursing staff (Nurse #2, Nurse #3, Nurse #4, Nurse #5, and the Weekend Nurse Supervisor) did not know the process for glucometer disinfection. Findings included: a. An observation was conducted on 9/4/24 at 11:48 AM of Nurse #2 performing a blood glucose check. After performing the blood glucose check Nurse #2 returned the glucometer to the middle drawer of the medication cart without disinfecting the glucometer. An interview with was conducted on 9/4/24 at 12:00 PM with Nurse #2. She said she thought she just needed to disinfect the glucometer before using it. Nurse #2 said she had received training on disinfecting glucometers during orientation when she had originally started working at the facility in 2020. Nurse #2 said she had left the facility and had been rehired around April 2024. She said she had not received training or education on glucometer disinfecting since she had been rehired. Nurse #2's employee file revealed a nurse	F 726	Each resident has their own glucometer that is stored individually in there designated bag with that residents name on it. On 9/5/24 after becoming aware of nurses not knowing the process for glucometer disinfection, DON spoke with each of the nurses and went over the proper procedures of cleaning each glucometer before and after use. All glucometers were disinfected. No residents are known to be affected as each resident requiring glucose monitoring has their own designated glucometer. However diabetic residents requiring blood glucose monitoring may have the potential to be affected by improper glucometer meter disinfection if a resident did not have their own glucomoter. Education provided by the facility Staff Development Coordinator has been ongoing to reach all nursing staff on various shifts on the steps to properly disinfect glucomoters per facility policy. In-service education began on 9/23/24 and will be completed with all nursing staff by 9/29/24. The process of disinfecting	

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F 726	Continued From page 13 orientation skills check list dated 2/15/24. Education on glucometer disinfection was not listed on the nurse orientation skills check list. b. An observation was conducted on 9/4/24 at 3:49 PM of Nurse #3 performing a blood glucose check. After performing the blood glucose check Nurse #3 used the same disinfectant wipe to clean the glucometer that she had used to clean the glucometer before using it and then returned the glucometer to the middle drawer of the medication cart. An interview was conducted on 9/4/24 at 4:00 PM with Nurse #3. She said she had used the same used disinfectant wipe to clean the glucometer because she had thought it was still wet and would be okay to use. Nurse #3's employee file revealed a nurse orientation skills check list dated 8/20/23. Education on glucometer disinfection was not listed on the nurse orientation skills check list. c. An interview was conducted on 9/4/24 at 2:00 PM with Nurse #4. She said glucometers were supposed to be cleaned/ disinfected after each use. She said that she used an alcohol prep pad to clean the glucometer after using it. She removed an alcohol prep pad from the top drawer of her medication cart and said it was what she used to clean the glucometer after using it. Nurse #4 said she could not remember if she had received education during orientation on glucometer disinfection. She said she did not remember if she had received education on glucometer disinfection since orientation. Nurse #4's employee file revealed a nurse	F 726	glucometers has been added to the new hire and annual skills checklist for all nurses. All nurses are being required to additionally read through the in-service material online through Paycom and sign that they have reviewed it. DON or designee will monitor to ensure nurses are disinfectiing glucomoters properly 3x per week for 4 weeks for 4 weeks or longer if the QAPI committee recommends it. Completion date: 09/30/2024	

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orientation skills check list dated 10/9/23. Education on glucometer disinfection was not listed on the nurse orientation skills check list.

d. An interview was conducted on 9/4/24 at 4:13 PM with Nurse #5. She said that she cleaned the glucometer after using it with an alcohol wipe from the medication cart. She removed an alcohol prep pad from the top drawer of her medication cart and said it was the alcohol wipe she used to clean the glucometer. Nurse #5 said she did not remember being educated on disinfecting glucometers. She said she cleaned the glucometer with an alcohol wipe after using it because she felt she needed to do something to clean off the germs after it had been used.

Nurse #5's employee file revealed a nurse orientation skills check list dated 11/30/23. Education on glucometer disinfection was not listed on the nurse orientation skills check list.

e. An interview was conducted with the Weekend Nurse Supervisor on 9/6/24 at 11:29 AM. She said she assisted with completing the nurse orientation skills list. She said that the skills list was completed for nurses annually and that she helped with the annual skills check. The Nurse Supervisor said she did not observe the nurse perform the tasks from the nurse skills check list except through her day-to-day work experience with the nurse. She explained when she completed a skills check list with a nurse she would sit down with the nurse and look over the skills check list with the nurse. She said she would read off each listed item from the skills check list and then ask the nurse if they had any questions about it. The Weekend Nurse Supervisor said if the nurse had questions about

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something from the skills check list or wanted to review an area then she would answer the questions they had and review that area specifically with the nurse. The Weekend Nurse Supervisor said that the category listed as infection control on the skills check list would include transmission-based precautions and how to put on or take off personal protective equipment. The Weekend Nurse Supervisor said that the category listed as orient to any durable medical equipment (DME) could include lifts, oxygen, or glucometers but that it did not include any specific DME. The Weekend Nurse Supervisor stated she did not review or provide education on glucometer disinfection when reviewing the skill check list with the nurses unless the nurse had a specific question about it. The Weekend Nurse Supervisor said if a nurse did have questions about how to disinfect the glucometer, she would tell the nurse that glucometers needed to be cleaned between use. She said she told the nurse an alcohol wipe or a disinfectant wipe could be used to clean the glucometer. The Weekend Nurse Supervisor said she had received training on disinfecting glucometers. She said that an alcohol wipe would not kill blood borne pathogens and that a disinfectant wipe would be better to use to clean the glucometer. She did not say why she told the nurses that an alcohol wipe could be used to disinfect the glucometer.

The weekend Nurse Supervisor's employee file revealed a nurse orientation skills check list dated 2/23/24. Education on glucometer disinfection was not listed on the nurse orientation skills check list.

An interview was conducted on 9/5/24 at 2:48 PM

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with the Staff Development Coordinator (SDC). The SDC stated that the nurse orientation skills check list was completed during on the floor orientation with whoever the new nurse was training with during on the floor orientation. She said that the facility did not have specific nurses designated to precept or train new nurses. The SDC stated that new nurses were trained on the floor by whichever nurse was working that day. The SDC said that glucometer education was not done with nurses during new hire orientation but that it was done annually. The SDC stated she was not sure if glucometer education was on the nurse skills check list specifically. After reviewing the skills check list the SDC stated that she did not see anything specific for glucometer education/ disinfection on the skills check list. She said that glucometer education could fall under the broader listed category of infection control or DME that was listed on the skills check list. The SDC said she would not know for sure if glucometer disinfection education had been provided to nurses during floor orientation because it was not specifically part of the skills check list. The SDC explained she had completed an annual in-service with nursing staff in February 2024 on how to clean/disinfect the glucometer. The SDC stated that the process to disinfect a glucometer should be to use one disinfectant wipe to clean the meter, use a second disinfect wipe to disinfect the meter, let the meter remain wet for two minutes, and then let it air dry. She said that the purpose of disinfecting a glucometer was to kill blood borne pathogens and that wiping the meter with an alcohol pad, or a damp cloth would not do that.

A facility in-service log was reviewed for an in-service entitled "How to clean a blood glucose

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meter" and revealed that the in-service had been conducted on 2/13/24. There were nine names on the in-service attendance log, including Nurse #4's name. Nurse #2, Nurse #3, Nurse #5, and the Weekend Nurse Supervisor's name were not present on the in-service attendance log. Review of the attached in-service literature revealed that the glucometer included in the in-service was a different glucometer than the glucometer currently in use at the facility.

A follow up interview was conducted with the SDC on 9/6/24 at 10:39 AM. The SDC stated that she was not sure why the other nurses had not received the in-service on "how to clean a blood glucose meter". She said that the in-service had not been a mandatory in-service for all nurses. She said that the nurses did not always come to in-services or trainings if it was their day off or they were busy. She stated that she did not go back and track down every nurse that did not come in-services or trainings. The SDC stated that when she had done the glucometer cleaning in-service in February that she had used the manufacture instructions from the glucometer for cleaning/ disinfecting the glucometer. The SDC said the glucometers came from the pharmacy and that the pharmacy may have changed the glucometers since the in-service.

An interview was conducted with the Director of Nursing on 9/6/24 at 9:32 AM. The DON stated that nurses should be trained on hire on the process for cleaning/ disinfecting glucometers by the nurse who was training them during on the floor orientation. She said that she assumed that education on glucometer disinfection would be covered under the broader category of infection control or DME listed on the nurse skills check

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F 726	Continued From page 18 list. The DON stated that there was not a way to identify specifically if the precepting nurse had trained and educated the new nurse on glucometer disinfection because it was not listed specifically on the skills check list. The DON said that there was not a way to know specifically on how nurses were trained or what process they were taught on how to disinfect the glucometers because the facility did not have a specific policy on how to disinfect glucometers. The DON stated that nurses should be educated on glucometer disinfection on hire and then annually. An interview was conducted with the Assistant Administrator on 9/6/24 at 10:22 AM. She said that the nurse skills check list did not specially include how to disinfect glucometers. She said that it could be included under infection control or DME categories listed on the skills check list. The Assistant Administrator could not say how she would know if education on glucometer disinfection was covered for nurses when the skills check list was completed since was not listed specifically. The Assistant Administrator said that nurses should be trained on glucometer disinfection on hire and annually. She said she was not sure why the nurses did not understand the disinfecting process for glucometers and needed re-education.	F 726		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law	F 755		9/30/24

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F 755	Continued From page 19 permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, staff and pharmacy technician interviews the facility failed to obtain an ordered antibiotic from the pharmacy which resulted in 2 missed doses of an antibiotic. This deficient practice occurred for 1 of 1 resident reviewed for pharmacy services (Resident #35). Findings included: Resident #35 was admitted to the facility on 2/16/22 with diagnoses that include hypoxemia, shortness of breath, and chronic obstructive	F 755	After becoming aware of residents Doxycycliine not being started on time, Assistant Administrator went into EMAR system and adjusted the end date of Doxycycline so that the resident would receive all the doses required for the orders. This was done on 9/4/2024 To prevent other residents potentially being affected by antibiotic not being started on time, Assistant Administrator reached out the the pharmacy to request	

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F 755	Continued From page 20 pulmonary disease (COPD). Review of Resident #35's active physician orders and medication administration record (MAR) for September 2024 revealed an active order dated 9/2/24 that read: Doxycycline (antibiotic) 100 mg tablet give one tablet by mouth two times a day for infection for 14 administrations. The order had been entered into the electronic computer system on 9/2/24 at 2:29 PM. The Doxycycline order was scheduled twice daily at 9:00 AM and 5:00 PM and had been scheduled to start on 9/2/24 at 5:00 PM. The MAR indicated that the first dose of Doxycycline had not been administered until 9/3/34 at 5:00 PM. Review of Resident #35's progress notes revealed a nursing note dated 9/2/24 at 10:27 PM by Nurse #4 that read in part: first dose of antibiotic not available in the back up and will be given as soon as arrival from pharmacy. An interview was conducted with Nurse #4 on 9/4/24 at 2:26 PM. Nurse #4 stated she had been the nurse assigned to Resident #35 on 9/2/24 when the Doxycycline had been ordered. She said that the Doxycycline had not been available in the facility's emergency backup medication kit. She said she had not called the pharmacy about the Doxycycline not being available because she had thought the medication would come on the next pharmacy delivery. Nurse #4 said that the pharmacy made two deliveries to the facility each day. She said that the first delivery was between 3:00 PM to 4:00 PM and that the second delivery was between 10:00 PM to 12:00 AM. An attempt was made to contact Nurse #4 for a follow-up interview but was unsuccessful.	F 755	Doxycycline to be added to the emergency kit to ensure the medication would be on hand for first dose in the future. Pharmacy added this medication to the facility emergency box on 9/9/2024. Education by the facility Staff Development Coordinator has been ongoing to reach all nursing staff on various shifts on expectations should a medication need arise on a holiday or after hours when the pharmacy may be closed. In-Service education began on 9/23/24 and will be completed with all nursing staff by 9/29/24. All nurses are being required to additionally read through the in-service material online through Paycom and sign that they have reviewed it. DON or designee will monitor for compliance of appropriate antibiotic start times after being ordered by the provider for 4 weeks or longer if the QAPI committee recommends it. Completion date: 09/30/2024	

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A progress note dated 9/3/24 at 9:52 AM by Nurse #7 read: Medication not arrived from pharmacy yet.
An additional progress note dated 9/3/24 at 2:37 PM by Nurse #7 read in part: Resident to be on antibiotic but it has not arrived from pharmacy.

An interview was conducted with Nurse #7 on 9/4/24 at 3:45 PM. Nurse #7 was Resident #35's assigned nurse for the day shift on 9/3/24. She stated that the Doxycycline had been ordered but had not arrived from the pharmacy during her shift on 9/3/24. She stated that the Doxycycline was not in the facility's emergency backup medication kit. Nurse #7 stated that she had not called the pharmacy about Resident #35's Doxycycline not being available because she had thought it would come on the first afternoon pharmacy delivery. Nurse #7 stated she had not worked on the 9/2/24 holiday and that she had not thought about the pharmacy being closed on 9/2/24 for the holiday when she had returned to work on 9/3/24.

A review of the list of medications included in the facility's emergency backup medication kit revealed Doxycycline was not a medication included in the facility's emergency backup medication kit.

A telephone interview was conducted on 9/5/24 at 10:25 AM with the Pharmacy Technician. She stated that the pharmacy had been closed on 9/2/24 for a holiday but that there had been an on-call pharmacist. She explained that if the facility had called the on-call pharmacist they could have filled the doxycycline prescription and had the medication delivered to the facility. The

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F 755	Continued From page 22 Pharmacist Technician stated that the pharmacy had received the Doxycycline order for Resident #35 on 9/2/24 at 2:27 PM and that the Doxycycline had not been delivered to the facility due to the holiday closure until 9/3/24 at 3:30 PM. An interview was conducted with the Director of Nursing (DON) and the Assistant Administrator on 9/6/24 at 10:23 AM. The Assistant Administrator stated that when Nurse #4 and Nurse #7 had looked in the emergency medication box and realized that the Doxycycline was not in the box that they should have called the pharmacy. The Assistant Administrator stated that an antibiotic should be started in under 24 hours.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Physician interviews the facility failed to administer an antibiotic as ordered for 1 of 1 resident reviewed for significant medication errors (Resident #35). Resident #35 missed two doses of an antibiotic. Findings included: Resident #35 was admitted to the facility on 2/16/22 with diagnoses that include hypoxemia, shortness of breath, and chronic obstructive pulmonary disease (COPD). Review of Resident #35's active physician orders for September 2024 revealed an active order	F 760	After becoming aware of residents Doxycycliine not being started on time, Assistant Administrator went into EMAR system and adjusted the end date of Doxycycline so that the resident would receive all the doses required for the orders. This was done on 9/4/2024 To prevent other residents potentially being affected by antibiotic not being started on time, Assistant Administrator reached out the the pharmacy to request Doxycycline to be added to the emergency kit to ensure the medication would be on hand for first dose in the	9/30/24

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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 760	Continued From page 23 dated 9/2/24 that read: Doxycycline (antibiotic) 100 mg tablet give one tablet by mouth two times a day for infection for 14 administrations. The order had been entered into the electronic medical record on 9/2/24 at 2:29 PM. The start date for the order was 9/2/24 at 5:00 PM. Review of the Nurse Practitioner (NP) progress note dated 9/6/24 revealed Resident #35 was being treated with Doxycycline for chronic obstructive pulmonary disease (COPD) exacerbation. The note indicated that Resident #35 was high risk for aspiration and had also recently been treated for pneumonia. Review of Resident #35's Medication Administration Record (MAR) for September 2024 revealed that the Doxycycline order was scheduled twice daily at 9:00 AM and 5:00 PM and had been scheduled to start on 9/2/24 at 5:00 PM. The 5:00 PM scheduled dose for 9/2/24 was unsigned/ blank on the MAR. The 9:00 AM dose on 9/3/24 had a 9 entered and was signed by Nurse #7. The MAR chart code section read: 9= other/ see progress note. The MAR indicated that the first dose of Doxycycline had not been administered until 9/3/34 at 5:00 PM. Review of Resident #35's progress notes revealed a nursing note dated 9/2/24 at 10:27 PM by Nurse #4 that read in part: first dose of antibiotic not available in the back up and will be given as soon as arrival from pharmacy. An interview was conducted with Nurse #4 on 9/4/24 at 2:26 PM. Nurse #4 stated she had been the nurse assigned to Resident #35 on 9/2/24 when the Doxycycline had been ordered. She said that the Doxycycline had not been available	F 760	future. Pharmacy has added this medication to the facility emergency box on 9/9/2024. Education by facility Staff Development Coordinator has been ongoing to reach all nursing staff on various shifts on expetations should a medication need arise on a holiday or after hours when the pharmacy may be closed. In-Service education began on 9/23/24 and will be completed with all nursing staff by 9/29/24. All nurses are being required to additionally read through the in-service material online through Paycom and sign that they have reviewed it. DON or designee will monitor for compliance of appropriate antibiotic start times after being ordered by the provider for 4 weeks or longer if the QAPI committee recommends it. Completion date: 09/30/2024	

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in the emergency medication kit. Nurse #4 stated that the pharmacy made two deliveries to the facility every day. She explained there was an early delivery from the pharmacy between 3:00-4:00 PM and then a later delivery between 10:00 PM- 12:00 AM. She said she had not called the pharmacy about the Doxycycline not being available because she had thought the medication would come on the next pharmacy delivery.

A progress note dated 9/3/24 at 9:52 AM by Nurse #7 read: Med not arrived from pharmacy yet.

An additional progress note dated 9/3/24 at 2:37 pm by Nurse #7 read in part: Resident to be on antibiotic but it has not arrived from pharmacy.

An interview was conducted with Nurse #7 on 9/4/24 at 3:45 PM. Nurse #7 was Resident #35's assigned nurse for the day shift on 9/3/24. She stated that the Doxycycline had been ordered but had not arrived from the pharmacy yet. She stated that the Doxycycline was not in the facility's emergency medication kit. She explained that the pharmacy usually made a first delivery of medications to the facility around 3:00 PM but that the pharmacy had not come before she had left on 9/3/24. Nurse #7 stated that she had not called the pharmacy about Resident #35's Doxycycline not being available because she had thought it would come on the first afternoon pharmacy delivery. Nurse #7 stated that she had not been aware the doxycycline had been ordered the day prior. She stated that she thought an antibiotic should be given with in 8-10 hours of it being ordered and that the first dose being given over 24 hours after it had been ordered was

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too long. She said that there had been memos from the pharmacy that had been posted in the medication room about the holiday. Nurse #7 stated she had not worked on the 9/2/24 holiday and that she had not thought about the pharmacy being closed on 9/2/24 for the holiday when she had returned to work on 9/3/24.

A review of the list of medications included in the facility's emergency backup medication kit revealed Doxycycline was not a medication included in the facility's emergency backup medication kit.

An interview was conducted on 9/5/24 at 10:25 AM with the Pharmacy Technician. She stated that the pharmacy had been closed on 9/2/24 for a holiday. She explained that the pharmacy had included a memo a week in advance in the pharmacy delivery totes to notify all facilities that the pharmacy would be closed on 9/2/24. She explained that the memo had included instructions regarding altered delivery times and needing to contact the on-call pharmacist if there were new prescriptions that needed to be filled on 9/2/24. The Pharmacist Technician stated that the pharmacy had received the Doxycycline order for Resident #35 on 9/2/24 at 2:27 PM and that the Doxycycline had been delivered to the facility on 9/3/24 at 3:30 PM. She stated that the pharmacy had only made one delivery for the 9/2/24 holiday as planned. The Pharmacy Technician stated that there had been an on-call pharmacist available on 9/2/24 and that if the facility had called the on-call pharmacist they would have filled Resident #35's Doxycycline and had it delivered to the facility.

An interview was conducted with Nurse # 1 on

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9/5/24 at 11:41 AM. Nurse #1 stated she had worked the weekend and had been off on Monday 9/2/24 for the holiday. She stated that there had been a pharmacy memo that had been posted about the pharmacy being closed on the Monday 9/2/24 holiday. Nurse #1 stated that the memo said what needed to be done if there was a new order on Monday 9/2/24 when the pharmacy was closed. Nurse #1 stated that the pharmacy memo had been posted on the medication room door, on the white board in the medication room, and at the emergency medication kit. Nurse #1 stated that if there had been a new order for a medication on Monday 9/2/24 and the medication was not available in the emergency medication kit that the nurse would have had to call the on-call pharmacist and that the on-call pharmacist would fill the medication and have it delivered to the facility as a special delivery.

An interview was conducted on 9/5/24 at 11:08 AM with the Medical Director (MD). The MD stated that in an ideal circumstance he would expect for an antibiotic to be started as soon as possible. The MD stated that in general orders should be implemented as soon as possible. He said that an antibiotic should not be delayed in being started for over 24 hours and that a delay of 24 hours in starting an antibiotic was too long. The Medical Director said that since Resident #35 had not had significant clinical symptoms he would have been okay with the antibiotic start being delayed but that a delay of over 24 hours was too long. He did not say specifically if missing the doses was significant.

An interview was conducted with the Director of Nursing (DON) and the Assistant Administrator on

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F 760	Continued From page 27 9/6/24 at 10:23 AM. The Assistant Administrator stated that she had entered the order for Resident #35's Doxycycline on 9/2/24. She said that no one was thinking about it being a holiday and pharmacy not coming because normally pharmacy would come again for a second run later at night. The Assistant Administrator stated that she did not normally enter new orders but that the nurse had asked her to help put in the order because the nurse had been with a family. The Assistant Administrator stated that it was normally the responsibility of whoever put the order into the computer system to check the emergency medication box to ensure that the medication was available in the box. The Assistant Administrator stated that she had not looked in the emergency medication box and had not realized that Doxycycline was not in the box. The Assistant Administrator stated that when the nurses looked in the emergency medication box and realized that the Doxycycline was not in the box that they should have called the pharmacy. The Assistant Administrator explained that the pharmacy would do special delivery's if they needed a medication that was not available. The Assistant Administrator stated that an antibiotic should be started in under 24 hours.	F 760		
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.	F 761		9/30/24

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F 761	Continued From page 28 §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 observations, staff and resident interviews, and record review the facility failed to secure antifungal powder for 1 of 1 resident (Resident #4) observed with prescription medicated powder at bedside. In addition, the facility failed to lock an unattended medication cart 1 of 4 medication carts (600-hall medication cart) observed for medication storage. The findings included: 1. Resident # 4 was admitted to the facility on 6/10/23 with diagnoses including dementia. A review of Resident #4's physician orders revealed an order dated 7/22/24 for Nystatin powder (antifungal powder) for affected area under both breasts 2 times daily. There was not a physician order for self-administration of nystatin powder.	F 761	On 9/6/24 after becoming aware of the medication cart being left unlocked, the DON immediately went to nurse and instructed her on the importance of always ensuring her cart remains locked when it is left unattended. Immediately following conversation with Nurse, DON went to the other medication carts to check if they were locked. All other carts were found to be locked. On 9/6/24 after becoming aware of medication being found in resident's room without an order, DON immediately went to the nurse responsible for that resident and instructed on the importance of bringing medications out of the room after use. DON then printed a list of medications that are ordered to be kept at bedside and a list of medications that are ordered that they can be	

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F 761	Continued From page 29 A review of the July 2024 medication administration record (MAR) revealed the antifungal powder was initialed by a nurse as applied as ordered each day beginning on 7/22/24. A review of the significant change minimal data set (MDS) dated 7/27/24 coded Resident #4 with moderate cognitive impairment. She required set up assistance for feeding and was dependent on staff for all other activities of daily living (ADL). A review of Resident #4's care plan dated 8/8/24 found no care plan for self-administration of medications. On 9/03/24 at 11:00 AM an in-room observation of Resident #4 found an open bottle labeled nystatin powder for topical use only, prescription only. The bottle was located on top of the resident's bedside table. During an interview on 9/3/24 at 11:00 AM Resident # 4 stated she was unaware how long the antifungal powder had been on her bedside table and she did not know which nurse had left it there. The resident indicated the nurses put the powder on her, and she was not able to apply the powder herself. An interview with the Wound Nurse on 9/3/24 at 11:29 AM revealed she was Resident #4's assigned nurse that day. She stated the nystatin powder should not have been stored at bedside and was unaware of how long it had been at bedside, and she did not know which nurse had used the powder most recently. The Wound Nurse said the antifungal powder should have	F 761	self-administered. DON then went room to room to ensure no other medications were left inside of room inappropriately. No other medications were located. DON then spoke to the nurses to ensure that medications were brought out of rooms immediately following use. Other residents would be at risk if other medications were left at bedside, or if medication carts were not locked. None were found. Education by Staff Development Coordinator is ongoing to reach all nursing staff on various shifts on the importance of leaving med carts locked when unattended, and that only meds that are ordered that can be left at bedside should be at bedside. In-Service education began on 9/23/24 and will be completed with all nursing staff by 9/29/24. All nurses are being required to additionally read through the in-service material online through Paycom and sign that they have reviewed it. DON or designee will monitor for compliance of medication carts being locked when cart is unattended, and medication being left at bedside 5x per week for 4 weeks or longer if the QAPI committee recommends it. Completion date: 9/30/2024	

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been stored in the treatment cart.

The Director of Nursing (DON) was interviewed on 9/6/24 at 10:32 AM. She stated Resident # 4 had an active order for the antifungal powder dated 7/22/24. The DON said Resident #4 did not have a physician's order for self-administration of the medication and it should not have been stored at the resident's bedside. The antifungal powder should have been stored in the treatment cart until needed for use.

2. A continuous observation was completed on 9/3/24 from 12:32 PM through 12:46 PM of the 600-hall medication cart.

-At 12:32 PM the 600-hall medication cart was observed unattended and unlocked as evident by the push tab lock protruding out. Staff were observed on the hallway passing out lunch trays. The medication cart was located outside of room 603. There were no residents visible in the hallway. Nurse #1 returned to the medication cart at 12:36 PM and locked the medication cart by pushing the push tab protruding lock inward before leaving the hall.

-At 12:42 PM Nurse #1 was observed as she returned to the 600-hall medication cart. Nurse #1 left the medication cart at 12:43 PM and entered a resident room. The 600-hall medication cart was observed unlocked as evident by the push tab lock protruding out. The medication cart was located outside of room 603. There were no residents visible in the hallway. Staff were visible nearby on the hallway assisting with lunch trays. Nurse #1 returned to the 600-hall medication cart

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F 761	Continued From page 31 at 12:46 PM. On 9/3/24 at 12:47 PM an interview was conducted with Nurse #1. She said that the medication cart was supposed to be locked when the nurse was not at the cart. Nurse #1 said she should have locked the medication cart but had forgotten. An interview was conducted on 9/3/24 at 9:32 AM with the Director of Nursing (DON). The DON said that Nurse #1 should have locked the medication cart before she walked away. She said the medication cart was supposed to be kept locked for safety so that someone walking by could not open the cart and access the medications. An interview was conducted with the Assistant Administrator on 9/3/24 at 10:22 AM. She said that Nurse #1 should have locked the medication cart when she left the medication cart.	F 761		
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 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:	F 880		9/30/24

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F 880	Continued From page 32 §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; §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.	F 880		

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F 880	Continued From page 33 §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 infection. §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, record review, and staff interviews the facility failed to establish and implement a policy and procedure for glucometer disinfection when Nurse #2 and Nurse #3 failed to disinfect a resident (Resident #21) glucometer after performing a capillary blood glucose test. This deficient practice occurred for 1 of 1 resident (Resident #21) reviewed for infection prevention and control. The findings included: The facility policy (undated) entitled "Glucose Monitoring-Easy Touch" read in part: Each resident is assigned their own meter which is to be disinfected before and after use. The facility policy did not specify how to disinfect the meter before and after each use. The facility did not have a separate policy and procedure for glucometer disinfection. The facility policy and procedure (undated) entitled "Standard Precautions" read in part: blood glucose monitor should be cleaned	F 880	Each resident has their own glucometer that is stored individually in a designated bag with residents name on it. On 9/5/24 after becoming aware of nurses not knowing the process for glucometer disinfection, DON spoke with each of the nurses and went over the proper procedures of cleaning each glucometer before and after use as well as disinfected all glucometers. No residents are known to be affected as each resident requiring glucose monitoring has their own designated glucometer. However diabetic residents requiring blood glucose monitoring may have the potential to be affected by improper glucometer meter disinfection if a resident did not have their own glucometer. Education by facility Staff Development Coordinator has been ongoing to reach all nursing staff on various shifts on the steps to disinfect glucomoter machines as	

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F 880	Continued From page 34 according to manufacturer recommendations. The glucometer User Instruction Manual read in part: when cleaning the meter, gently wipe the exterior surface using a damp soft cloth. Do not use any organic solvent for cleaning. For healthcare professionals using this system on multiple patients, please be aware that all items that come in contact with human blood should be handled as potential biohazards. Users should follow the guidelines for prevention of blood-borne transmittable disease in a healthcare setting for potentially infectious human blood specimens as recommended in the national Committee for Clinical laboratory Standards, Protection of Laboratory Workers from Instrument Biohazards and Infectious Disease Transmitted by Blood, Body Fluids and Tissue. a. An observation was completed on 9/4/24 at 11:48 AM of Nurse #2 performing a blood glucose test for Resident #21. Nurse #2 removed the glucometer from the middle drawer of her medication cart. The glucometer was stored in the manufacturer's zippered storage bag and labeled with Resident #21's name. Nurse #2 gathered supplies (an alcohol pad, lancet, and test strips). Nurse #2 was accompanied as she carried the glucometer and supplies down to Resident #21's room. After entering the room, the nurse put the glucometer and supplies down on the resident's bed. While wearing gloves, the nurse wiped the resident's finger with an alcohol pad, used a lancet to obtain a drop of blood from her finger and applied the blood to the test strip inserted into the glucometer. Once the blood glucose results were obtained, Nurse #2 discarded the trash and lancet, and returned to the medication cart with the glucometer. She	F 880	stated in the updated facility policy and procedure. In-Service education began on 9/23/24 and will be completed with all nursing staff by 9/29/24. All nurses are being required to additionally read through the in-service material online through Paycom and sign that they have reviewed it. DON or designee will monitor to ensure nurses are disinfectiing glucomoters properly 3x per week for 4 weeks for 4 weeks or longer if the QAPI committee recommends it. Completion date: 09/30/2024	

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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
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placed the glucometer back into the manufacturer's zippered storage bag and zipped the bag closed and returned the glucometer to the middle drawer of the medication cart. There were disinfectant wipes present on the medication cart.

An interview was performed with Nurse #2 on 9/4/24 at 11:55 AM. Nurse #2 said that she had cleaned the glucometers prior to performing Resident #21's blood glucose check. She explained she had used a disinfectant wipe to wipe the surface of the glucometer off to clean it. Nurse #2 said that glucometers were not shared and were for individual use. She said glucometers were stored on the medication cart. Nurse #2 stated she was unsure why the facility stored glucometers on the medication cart and not in the resident room, she said that was how the facility had always done it. Nurse #2 said she did not disinfect the glucometer after performing Resident #21's blood glucose check because she thought she just needed to clean it prior to using it. She explained the reason glucometers needed to be disinfected was to prevent transmission of blood borne pathogens. Nurse #2 stated that Resident #21 was the only resident on the hallway that received blood glucose checks and that the glucometer for Resident #21 was the only glucometer stored on the medication cart.

b. An observation was performed on 9/4/24 at 3:49 PM of Nurse #3 performing at blood glucose test for Resident #21. Nurse #3 removed the glucometer from the middle drawer of the medication cart. The glucometer was stored in the manufacturer zippered pouch and labeled with Resident #21's name. She donned gloves and obtained a disinfectant wipe. She used the

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	345413	A. BUILDING _____ B. WING _____	C 09/06/2024

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disinfectant wipe to wipe the surfaces of glucometer. She then placed the glucometer with the used disinfectant wipe under it, onto the opened surface of the manufacture zippered pouch on top of the medication cart. Nurse #3 gathered supplies (an alcohol pad, lancet, and test strips). Nurse #3 was accompanied as she carried the glucometer on the opened zippered manufacture pouch with the used disinfect wipe under it and supplies down to Resident #21's room. After entering the room, Nurse #3 put the opened manufacture zippered pouch containing the glucometer on top of the used disinfect wipe and supplies down on the resident's bed. While wearing gloves, the nurse wiped the resident's finger with an alcohol pad, used a lancet to obtain a drop of blood from her finger and applied the blood to the test strip inserted into the glucometer. Once the blood glucose results were obtained, Nurse #3 discarded the trash and lancet, but kept the used disinfectant wipe under the glucometer. Nurse #3 returned to the medication cart with the glucometer still on top of the used disinfectant wipe that was sitting on the opened manufacture zippered pouch. Nurse #3 proceeded to use the same used disinfectant wipe to wipe the surface of the glucometer and then zipped the manufacture storage pouch closed and returned it to the middle drawer of the medication cart.

An interview was conducted on 9/4/24 at 4:00 PM with Nurse #3. She said that glucometers were for individual use and stored in the medication cart. Nurse #3 said that the glucometer was supposed to be disinfected before and after each use. She said that a new disinfectant wipe was supposed to be used to disinfect the meter after performing a blood glucose check. Nurse #3 said

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she had thought it was okay to use the same disinfectant wipe to disinfect the glucometer after she had used it because she thought it was still wet, but that she probably should have gotten a new disinfectant wipe. Nurse #3 stated that glucometers were stored in the medication cart so that they were easily accessible for the nurses.

An interview was conducted on 9/5/24 at 2:48 PM with the Staff Development Coordinator (SDC). The SDC stated that the process for glucometer disinfection was to use one disinfectant wipe to clean the meter, use a second disinfect wipe to disinfect the meter, let the meter remain wet for two minutes, and then let it air dry. She said that the purpose of disinfecting a glucometer was to kill blood borne pathogens.

An interview was conducted on 9/6/24 at 9:32 AM with the Director of Nursing (DON). The DON said that glucometers were supposed to be disinfected using an environmental protective agency (EPA) approved disinfectant wipe before and after each use. She explained to disinfect the meter the nurse should use one wipe to clean the meter and then use a new wipe to disinfect the meter before and after use. The DON said that glucometers were for individual resident use and not shared. The DON stated that glucometers were stored in the manufacturer's storage pouch on the medication cart. She said glucometers were stored on the medication cart because that was where they had always been stored. The DON explained that nurses performed the blood glucose checks, and the glucometers were stored on the medication cart for accessibility. The DON explained that the facility did not store glucometers in resident rooms because they could get lost and would not be accessible when

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needed. She did not say why the facility policy did not say how to disinfect the glucometer.

An interview was conducted with the Assistant Administrator on 9/6/24 at 10:22 AM. She said that glucometers should be disinfected before and after each use with a new EPA disinfectant wipe. The Assistant Administrator said that glucometers needed to be disinfected to prevent blood borne pathogen transmission. She said a damp cloth would not kill blood borne pathogens. The Assistant Administrator stated that glucometers were stored in the medication cart. She said the facility did not store glucometers in resident rooms because they might get lost.