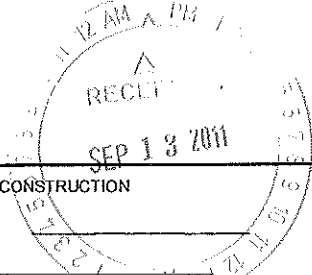


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/02/2011  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345143	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/06/2011
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NAME OF PROVIDER OR SUPPLIER  SILER CITY CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN ST SILER CITY, NC 27344
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F 000	INITIAL COMMENTS  The 2567 was amended 6/10/2011 changing scope and severity of F441 from "D" to "J" and Resident #126 to Resident #128. The credible allegation was added 6/16/2011.  As a result of informal dispute resolution conducted on July 18, 2011, the severity of this citation was reduced to a "D" which means there was no actual harm with potential for more than minimal harm that is not jeopardy.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, <del>Siler City Care &amp; Rehabilitation Center</del> does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."  F 226  The payroll coordinator and SDC reviewed employee personal files that were hired in the last 90 days for references on 5/24/11. Any employee found not to have references; will be obtained by department head by 5/31/11.  Department Heads were re educated on the process of checking for references prior to offering the applicant employment by Administrator on 5/24/11.  The HR Coordinator will attach the "New Hire Checklist" to applications. The "New Hire Checklist" includes but not	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to screen prior employment references for 2 of 5 new hires, prior to offering employment.  The findings include:  On 5/5/11 at 3:00pm, the facility's Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property Policy dated January, 2008 was reviewed. It read that "The Department Head/designee screens potential employees in accordance with state and federal law prior to their first day of employment for a history of abuse, neglect, or mistreatment of residents." It further read that prior employment	F 226		5/31/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 9-9-11
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	<p>Continued From page 1</p> <p>reference checks involved obtaining information from previous employers or current employers.</p> <p>1. On 2/14/11, Nurse Aide #1 was hired by the facility. Her prior employment references were checked on 3/18/11.</p> <p>On 5/5/11 at 3:20pm, the Central Supply Coordinator/Scheduler was interviewed. She stated that their current process for hiring nurse aides involved the Director of Nursing Services (DNS) screening and interviewing candidates for employment. Then the DNS made arrangements for criminal background checks, immunizations and drug testing. Once the potential employee passed all three screenings, a job offer was made. When they confirmed that the offer was accepted; payroll or the staff development coordinator (SDC) gave her a copy of the application and asked her to check references. She stated, " They just hand it to me and say get to it. Usually, I do it within a day or so. "</p> <p>The Scheduler continued by stating that she was on medical leave after 12/30/11 for 4 ½ weeks and her duties were covered by other individuals. She stated that NA #1 ' s references were checked on 3/18/11 because that ' s when she received the paperwork. She didn ' t know why there was a delay in getting the paperwork from the other departments. She further commented that she had never had a bad reference on anything that she had screened.</p> <p>On 5/6/11 at 3:26pm, the Payroll Coordinator was interviewed. She shared that the Department Head was supposed to do the references, commenting that " Ideally, references are done</p>	F 226	<p>limited to, and item to date when the application is completed by applicant, date when the 2 references were checked, date drug screening was complete and date that the criminal background was completed. Employment will not be offered until references have been checked and signed off by Department Manager/Designee.</p> <p>The HR Coordinator will complete monthly audits to include completed application, 2 reference checks, drug test completed, and criminal background completed on all employees hired the prior month and results will be reported by SDC monthly at the Performance Improvement meeting x 3 months.</p>		

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F 226	<p>Continued From page 2</p> <p>before I get the file. I don ' t know if that ' s before hiring or not. We just took note that they were late. " She explained that there was a selection of new hires that the SDC nurse stated did not have reference checks on them, so she gave them to the Scheduler to complete because the DNS was busy with hiring.</p> <p>On 5/6/11 at 4:26pm the DNS was interviewed. She explained that she conducted interviews for Nurse Aides. Once she decided to hire them, she would give the file to the SDC nurse to coordinate background checks, drug screens and immunizations. The Central Supply/Scheduler was responsible for doing the reference checks. She stated that " Reference are done after the candidate is offered the position. " She didn ' t know why it was done after employment was offered, but believed it was their policy.</p> <p>2. On 3/21/11, Nurse Aide #5 was hired by the facility. Her prior employment references were checked on 3/25/11. Her former employer commented to the Central Supply/Scheduler that although NA #5 was eligible for rehire as a direct care worker, she said " She was not qualified. "</p> <p>On 5/5/11 at 3:20pm, the Central Supply Coordinator/Scheduler was interviewed. She stated that their current process for hiring nurse aides involved the Director of Nursing Services (DNS) screening and interviewing candidates for employment. Then the DNS made arrangements for criminal background checks, immunizations and drug testing. Once the potential employee passed all three screenings, a job offer was made. When they confirmed that the offer was accepted; payroll or the staff development</p>	F 226			

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F 226	<p>Continued From page 3</p> <p>coordinator (SDC) gave her a copy of the application and asked her to check references. She stated, " They just hand it to me and say get to it. Usually, I do it within a day or so. "</p> <p>The Scheduler continued by stating that she was on medical leave after 12/30/11 for 4 ½ weeks and her duties were covered by other individuals. She stated that NA #5 ' s references were checked on 3/25/11 because that ' s when she received the paperwork. She didn ' t know why there was a delay in getting the paperwork from the other departments. She further commented that she had never had a bad reference on anything that she had screened.</p> <p>On 5/6/11 at 3:26pm, the Payroll Coordinator was interviewed. She shared that the Department Head was supposed to do the references, commenting that " Ideally, references are done before I get the file. I don ' t know if that ' s before hiring or not. We just took note that they were late. " She explained that there was a selection of new hires that the SDC nurse stated did not have reference checks on them, so she gave them to the Scheduler to complete because the DNS was busy with hiring.</p> <p>On 5/6/11 at 4:26pm the DNS was interviewed. She explained that she conducted interviews for Nurse Aides. Once she decided to hire them, she would give the file to the SDC nurse to coordinate background checks, drug screens and immunizations. The Central Supply/Scheduler was responsible for doing the reference checks. She stated that " Reference are done after the candidate is offered the position. " She didn ' t know why it was done after employment was</p>	F 226			

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F 226	Continued From page 4 offered, but believed it was their policy.	F 226		
F 246 SS=D	<p>Regarding NA #5 's reference check, the DNS stated that she was not aware that her former employer commented that she was not qualified for the position. She shared that her expectation would have been to call the reference back to inquire further.</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and medical record review the facility failed to offer fluids between meals for 1 of 3 sampled residents dependent for activities of daily living (Resident #66).</p> <p>Resident # 66 was admitted on 4/6/2005 and had diagnoses including but not limited to Diabetes Type II, hypertension and dementia. The significant change minimum data set (MDS) assessment dated 2/8/11, revealed the resident had short and long term memory problems and was severely impaired in decision making. The MDS also revealed Resident #66 was dependent for all activities of daily living (ADL 's) including eating and drinking fluids and that he required a</p>	F 246	<p>F 246</p> <p>Resident # 66 was given ice water and offered a drink 5/4/11 by 3-11 nursing assistant. Resident # 66 is offered/assisted with a drink of fluid during ice pass if awake and during hydration pass at 10am <del>2pm</del> bedtime by the nursing assistant, and all med passes by Charge Nurse.</p> <p>Audit was completed on 5/5/11 on the halls by RN Supervisor to ensure that ice water was passed to residents and fluid was being offered to dependent residents. Residents that are dependent or require cueing were identified by review of the MDS Section G. The Nursing Assistant Care Card identifies which residents need cueing and assistance.</p> <p>Re-education for licensed nurses and nursing assistants was performed on 5/4/11 and on 5/5/11 by SDC which included offering fluids to dependant and residents that need cueing during ice pass and during hydration pass at 10 am 2 pm</p>	5/31/11

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F 246	<p>Continued From page 5</p> <p>one person physical assist for ADL ' s.</p> <p>Review of the Care Plan for Resident #66 revealed the following focus area had an initiated date of 12/15/2009 and a revised date of 2/24/11: " Resident is dependent for all adls (activities of daily living) related to immobility, weakness, cognition, vision and communication impairment " . The interventions for this focus area included, in part, " Offer and encourage fluids. "</p> <p>Interview with Resident #66 ' s room mate, who was a family member, on 5/4/11 at 11:00 AM revealed that 200 hall staff sometimes had not passed ice water every shift and that when they did deliver the ice water not all the staff offered Resident #66 a drink. She also stated that when she was in the room with Resident #66 during the ice water pass, she often needed to ask the Nursing Attendant (NA) to offer Resident #66 a drink as they would otherwise just leave the cup of ice water without offering him a drink. She also noted that this was more of a problem on day shift (first shift 7 AM - 3 PM) but also depended on which staff member was passing the ice water. No particular staff members were identified.</p> <p>Observation of resident #66 on 5/4/11 at 11 AM revealed the resident appeared hydrated with moist oral mucous membranes.</p> <p>On 5/4/11 at 3:00 PM interview with Nursing Assistant (NA) #2 revealed on first shift ice water distribution was routinely assigned to one NA by the nurse. NA #2 also stated that the NA who was responsible for ice water distribution would know they were assigned to distribute water and</p>	F 246	<p>and at bedtime. . Charge nurse on each shift will complete an audit sheet indicating if ice pass occurred. Nursing assistants will indicate on nursing assistant worksheet if ice pass occurred and if water was offered to dependent residents or residents that need cueing. Nursing assistant will complete a hydration check sheet to indicate if resident accepted or refused liquid during hydration pass.</p> <p>An audit on each hall and each shift will be completed weekly x 4 weeks and then <del>monthly x 2 months</del> by Supervisors to ensure ice water is passed. Results will be reported to the Director of Nursing and discussed/presented in the monthly Performance Improvement meeting x 3 months.</p>	

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F 246	<p>Continued From page 6</p> <p>or ice because their name would be written at the top of the assignment sheet beside the word ice. When asked if he was responsible for distributing ice water for hall 200 on first shift for 5/4/11 he stated NA #3 " was supposed to do it today. " He also stated that ice water is normally distributed at the beginning of the shift.</p> <p>Review of the Nursing Assistant Worksheet dated 5/4/11 with the check box for " 7-3 shift " checked revealed a hand written notation at the top of the page that stated " Ice: (name of NA #3) "</p> <p>On 5/4/11 at 3:05 PM NA #3 was interviewed. When asked when she passed ice water to the rooms on hall 200 NA #3 stated " I was just about to do it. " NA #3 acknowledged that first shift was already over but stated she often stays late and denied that there was a particular time that ice water should be distributed during the shift. She stated that she had provided ice water to some individual residents during first shift on 5/4/11 but that she had not used the ice cart. When asked to specify the room numbers she specified six residents that she had provided ice water to on hall 200 on 5/4/11. NA #3 did not reveal a rationale for having provided ice water to some residents and not to others. Resident #66 ' s room was not one of the rooms she had delivered ice water to on hall 200. NA #3 also stated that part of the responsibility of the staff member passing ice water is to offer a drink to any residents who are unable to drink on their own. She then indicated she did not offer Resident #66 on 5/4/11 during first shift.</p> <p>On 5/4/11 at 3:10 PM NA #3 stated she was</p>	F 246		

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F 246	<p>Continued From page 7</p> <p>going to go and deliver the first shift ice water. It was pointed out to her that second shift had already started distributing ice water for second shift and could be observed on the hall with the ice water cart. NA #3 then indicated it was too late to deliver first shift ice water and that the opportunity to offer fluids had been missed.</p> <p>On 5/4/11 at 3:15 two NA 's were observed passing ice water on hall 200 using the ice cart. One of the NA 's provided ice water to resident #66 and assisted him in taking a drink of water.</p> <p>On 5/4/11 at 3:25 NA #4 was observed passing ice water on hall 200 and was interviewed . He stated that he was passing ice water for second shift and that ice water is supposed to be distributed at the beginning of each shift.</p> <p>Interview of Nurse #4 at 3:30 PM on 5/4/11 revealed that she had been the first shift nurse in charge of hall 200 but that she had been unaware ice water had not been passed. She stated that NA #3 did not tell her she was having problems completing the ice water pass and that she would have expected NA #3 to let her know so help could be provided. Nurse #4 stated that ice water was to be distributed at the beginning of each shift and not at the end and that dependent residents like, Resident #66, needed to have physical assistance to drink when the ice water was passed.</p> <p>Interview with NA #2 on 5/4/11 at 3:40 PM revealed he was assigned to Resident #66 on 5/4/11 first shift. He stated that he had been in the room providing incontinent care on two occasions, once in the morning and once in the</p>	F 246			



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F 246	<p>Continued From page 8</p> <p>afternoon but that he had not offered Resident #66 a drink on either occasion, or on any other occasion throughout first shift. He further said that he was aware that he should have offered dependent residents like Resident #66 fluids whenever entering the room. NA #2 said that he was unsure how much Resident #66 had to drink during first shift on 5/4/11, as another NA had fed the resident breakfast and lunch. He revealed that oral intake from breakfast and lunch was recorded on the Nursing Assistant worksheet.</p> <p>Review of the "Nursing Assistant Worksheet" for 5/4/11 7 - 3 shift revealed the resident drank 360 ml (milliliters) of fluid for breakfast and refused fluids at lunch.</p> <p>Observation of Resident #66 on 5/4/11 at 3:50 PM revealed the resident appeared hydrated with moist oral mucous membranes.</p> <p>Interview with the Director of Nursing (DON) on 5/4/11 at 4 PM revealed that on every shift NA 's were expected to pass ice water to all residents. She further stated that the NA passing ice water is expected to cue residents who need cueing and to provide physical assistance in drinking fluids to dependent residents like Resident #66. In addition, when nursing staff enter the residents room it was her expectation that fluids are offered, particularly to dependent residents and those who need cueing to drink. The DON revealed that the NA 's who were assigned to passing ice water were expected to use the ice cart when they completed the ice water pass. In addition, the DON stated that it was her expectation that any NA who was getting behind in their work and could not complete the ice water</p>	F 246		

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F 246	Continued From page 9 pass should have informed the lead NA or Nurse early in the shift, such as before lunch for first shift, so that assistance in completing the ice water pass could have been provided.	F 246		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens	F 441	F 441 Unit Manager obtained an order from physician on 5/5/11 for Liver panel, HIV, and Hepatitis panel. to be drawn on 5/6/11 and repeat in 3 months on resident #26. Labs were drawn 5/ 6/11 with lab valves being normal.  Residents receiving finger sticks received assessments for nausea, vomiting, feeling of increased fatigue, decreased appetite, by Unit managers/ supervisors on 5/5/11  Licensed nurse # 1 was re educated on 5/4/11 by SDC which included how, when, how long and what cleaner/disinfectant to use in cleaning/disinfecting of glucometer use between residents. MD consulted on all other Residents that were at potential risk; due to level of risk and completed assessments there is not a need for labs on those Residents at this time. Licensed nurses were re educated on how, when, how long and what cleaner/disinfectant to use in cleaning and disinfecting glucometer between residents with return demonstration on 5/4/11 and 5/5/11 by SDC. SDC will re educate	5/31/11

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NAME OF PROVIDER OR SUPPLIER  SILER CITY CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN ST SILER CITY, NC 27344		
(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 441	<p>Continued From page 10</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to clean and disinfect one (1) of five (5) glucometers before performing blood glucose testing on two (2) (Resident #26 &amp; #128) of seventeen (17) residents.</p> <p>Findings included:</p> <p>The Blood Glucose Monitoring System User Guide read in part, "Cleaning Your Monitor ...Healthcare professionals: Acceptable cleaning solutions include 10% bleach, 70% Alcohol, or 10% Ammonia."</p> <p>The facilities policy and procedure titled, "Caring for Your Glucometer-a guide to assist centers in maintaining the cleanliness, disinfection and proper functioning of the glucometer" dated 12/2009 and revised 2/2010 was reviewed. The policy indicated the center was to clean and disinfect only with 1:10 bleach (10%) in the form of wipes or towelettes between each resident use.</p> <p>The label of (name brand) Germicidal Disposable Wipe, an EPA approved disinfectant read in part: "Meets OSHA (occupational and safety health standards) blood borne pathogen standards. Kills bacteria, viruses and fungi in 1 minute on hard, nonporous surfaces. Kills TB (tuberculosis) in 2</p>	F 441	<p>licensed nurses on each shift on cleaning/disinfecting glucometer monthly x 3 months. Newly employed licensed nurses will be educated on glucometer cleaning disinfection during orientation by SDC.</p> <p>SDC and/or supervisor will observe 5 nurses weekly, randomly choosing nurses on each shift performing finger sticks on residents x one month then 5 licensed nurses monthly x 2 months. The observation will be recorded on the glucometer skills check sheet by the SDC/supervisor whom is completing the observation.</p> <p>Results of the observations will be presented to PI committed monthly x 3 months by SDC and/or Director of Nursing Services</p>		

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F 441	<p>Continued From page 11 minutes."</p> <p>The Center for Disease Control (CDC) and Prevention Guidelines for Glucose Monitoring read in part, "Any time blood glucose monitoring equipment is shared between individuals there is a risk of transmitting viral hepatitis and other blood borne pathogens. Decontaminate environmental surfaces such as glucometers regularly and any time contamination with blood or body fluids occurs or is suspected. Glucose test meters approved for use with more than one person must be cleaned and disinfected following disinfection guidelines."</p> <p>The following observations were continuous. The observation began on 5/04/2011 at 3:55pm with Resident #124's finger stick observation. The continuous observation concluded with Resident #128 at 4:41pm on 5/04/2011.</p> <p>Nurse #1 was observed performing a finger stick blood sugar test on Resident #124 on 5/04/2011 at 3:55pm. The Nurse entered the resident's room with the glucometer with the glucose strip inserted into the machine. The Nurse was wearing gloves. The resident's finger was pricked using a new lancet, and a drop of blood was collected on the test strip. After the test was completed Nurse #1 placed the machine on top of the medication cart without the benefit of being cleaned or disinfected. The Nurse prepared and administered medications for another resident. Record review of Resident #124 on 5/04/2011 at 5:20pm revealed an admission date of 8/23/2010 with multiple diagnoses including Uncontrolled Diabetes Mellitus Type II.</p>	F 441			

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F 441	<p>Continued From page 12</p> <p>Nurse #1 was observed at 4:03pm to perform a finger stick blood sugar test on Resident #26 using the unclean or disinfected meter. The Nurse entered the resident's room carrying the uncleaned or disinfected glucometer with a fresh glucose strip inserted into the machine. Nurse #1 was wearing gloves. The resident's finger was pricked using a new lancet, and a drop of blood was collected on the test strip. After the test was completed Nurse #1 placed the machine on top of the medication cart without the benefit of being cleaned and disinfected. The Nurse prepared and administered medications for other residents. This was a continuous observation. Record review of Resident #26 on 5/04/2011 at 5:25pm revealed an admission date of 12/23/2010 with multiple diagnoses including Diabetes Mellitus Type II.</p> <p>Nurse #1 was observed at 4:41pm preparing to perform a finger stick blood sugar test on Resident #128 using the uncleaned or disinfected glucometer. She inserted a fresh glucose strip into the machine and obtained a new lancet from the top drawer of the medication cart. She donned gloves and proceeded toward Resident #128's room. At that time the surveyor asked Nurse #1 about the glucometer cleaning procedure. She said she was supposed to clean the glucometer after each finger stick. She said she cleaned the glucometer after one of the finger sticks but she could not state which one. Nurse #1 admitted she did not clean the glucometer after using it on each resident.</p> <p>An interview was conducted on 5/04/2011 at 5:10pm with Nurse #2 regarding the use, cleaning and disinfecting of the glucometers. Nurse #2</p>	F 441		

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F 441	<p>Continued From page 13</p> <p>said the glucometer is to be cleaned after each finger stick with the wipe they use.</p> <p>An interview of Nurse #3 was conducted on 5/04/2011 at 5:15pm regarding the use, cleaning and disinfecting of the glucometers. Nurse #3 said after each finger stick the glucometers is to be wiped with the wipes that are kept on the carts.</p> <p>An interview of the DON (Director of Nursing) was conducted and on 5/04/2011 at 5:36pm. She said she expected the glucometers to be cleaned after each use and for the nurses to follow the policy the facility had in place.</p> <p>An interview with the Staff Development Nurse (SDC) was conducted on 5/04/2011 at 6:36pm. She was accompanied by the Regional Nurse Consultant. The SDC said she teaches the staff to apply the disinfecting product to the glucometer after each finger stick.</p> <p>On 5/04/2011 at 7pm the SDC provided a copy of a mandatory in service training roster dated 3/19/2011. The inservice included the cleaning of equipment used to test blood sugars. The roster included the name of Nurse #1.</p>	F 441		