STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345466	A. BUILDING _____ B. WING _____	C 08/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOK REHABILITATION AND CARE CENTER	333 EAST LEE STREET YADKINVILLE, NC 27055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 8/31/12. Event ID# IHIE11.	F 000		

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

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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to provide meal trays to all residents at a table resulting in one (1) of three (3) residents waiting for the meal tray and assistance. Resident #62. The findings were: Resident #62 was admitted to facility on 12/16/09 with diagnoses including History of stroke, Alzheimer's, OP, OA, hypothyroidism. Review of the Minimum Data Set, dated 8/8/12 assessed Resident #62 with impaired short and long term memory problems and required extensive assistance with eating. Review of the care plan with a revised date of 8/9/12, for a problem of potential for weight loss due to unstable health condition, variable intake and below ideal body weight. Approaches for staff to take for this problem included maintaining a pleasant environment at mealtimes, use non spill cup and avoid resident's food dislikes. Continuous observations began on 8/27/12 at 5:30 PM of dining in the main dining room. The first cart of meal trays arrived at 5:53 PM. The staff in the dining room during this observation included the maintenance director, three aides	F 241	#1 The employee in question was trained one-on-one by the Director of Clinical Services about the dignity of feeding residents while being seated. Resident #62 has been fed subsequent meals at the same time as the rest of the residents seated at her table with the C.N.A. seated during the process of feeding her. #2 Current residents are at risk for the deficient practice. The current licensed and certified staff have been re-educated as to the facility policy and procedure on feeding residents requiring total assist and serving meals. This education included the requirement of all residents at each table receive trays and assistance at the same time for dependent and independent residents by the Director of Clinical Services, Unit Manager, or Weekend Supervisor. This education will be provided to newly hired licensed and certified nursing staff during the orientation process.	8/30/2012 8/31/2012 10/1/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jina Bibbs LNHA — TITLE: Administrator — (X6) DATE: 10/4/12

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F 241	Continued From page 1 and a nurse. One table of three residents was observed. Aide #1 obtained a tray for one of the three residents, sat between her and the second resident, and began feeding her the meal at 5:59 PM. The other two residents did not have their trays or any food items in front of them. The second resident received a tray at 6:02 PM and aide #2 began feeding her. Resident #62 was the third resident at this table. Resident #62 sat and watched the other two residents while they were fed. Resident #62 received her tray at 6:35 PM and was fed the meal by aide #1. Observations concluded at 6:45 PM. Observations were made on 8/28/12 at 1225PM of the main dining room. The trays arrived in dining room at 12:25PM. Observations were made of Resident #62 and two other residents at her table. Resident #62 received her tray at 12:42PM. Aide #3 stood beside Resident #62 and assisted her with holding the spoon, taking a few bites of food. He left her to begin feeding the other two residents. Observations of Resident #62 revealed she reached towards the food, and withdraws her hand. Resident #62 was observed not eating or drinking during this time. Observations at 1:00 PM revealed the Director of Nursing was observed asking staff member #3 to assist Resident #62. The staff member #3 replied, he did not know she required assistance. He further replied he was already assisting two residents and someone would have to wait. Aide #3 then stopped feeding the two residents, and walked beside Resident #62. He stood beside her, and fed her some of the meal. After three minutes, another staff member came, and fed Resident #62.	F 241	#3 The Certified Dietary Manager, Director of Clinical Services and Safety Director re-assessed the seating arrangement in the dining room. The seating arrangement has been updated to place residents needing assistance with meal intake are seated together and residents requiring little to no assistance are seated together. The alert and oriented residents were interviewed as to their seating arrangements in the dining room for meals. No changes were indicated at that time. The Administrator, Director of Clinical Services Weekend Supervisor, Unit Manager, Medical Records Director and/or Safety Director will complete a performance improvement tool daily x 14 days, then 5 days per week x 2 weeks, then 3 days per week for two weeks, then weekly x 2 weeks, then monthly x 10 months to monitor the seating arrangement, compliance with assisting residents with meal intake simultaneously at each table, and/or each resident at each table receive their tray together.	9/14/2012 9/14/2012

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F 241	Continued From page 2 Interview with the Maintenance Director on 8/30/12 at 12:00 PM revealed he does not feed resident, but passes out the trays. He is aware all trays should be passed to one table before going to the table. Interview on 8/30/12 at 12:05 AM with aide #1 who worked 8/27/12 and fed another resident while Resident #62 waited: usually feed one certain resident. All residents should have their trays and someone should be available to feed the other residents. Another aide should have fed Resident #62 while she fed the one resident. Interview with the Director of Nursing on 8/3012 at 230PM revealed her expectation of staff when in dining room feeding residents would be for residents sitting at same table to be fed at same time. One resident should not be fed, and others have left waiting. During this interview, she replied the aides should not stand to provide feeding assistance to residents.	F 241	#4 The results of the Performance Improvement tool will be presented to the Performance improvement Committee by the Administrator or Director of Clinical Services monthly x 12 months to identify trends and need for further monitoring and/or education.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431		

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F 431	Continued From page 3 appropriate accessory and cautionary instructions, and the expiration date when applicable. 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. 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 interviews and policy review the facility failed to: 1. remove expired medications from one (1) of two (2) medication roooms and one (1) of three (3) medication carts; 2. maintain proper temperatures in medication refrigerators for medication storage in two (2) of two (2) medication refrigerators and 3. maintain cleanliness of the inside of the medication refrigerators for two (2) of two (2) medication refrigerators. The findings were: Observations on 8/3012 at 9:20 AM of the	F 431	#1 Expired mediations have been removed from medication room and medication carts. Thermometers were replace in the Medication room refrigerators and are maintaining proper temperature for medication storage. Medication refrigerators have been cleaned. #2 Current residents are at risk for the deficient practice. The current licensed staff have been re-educated by the Director of Clinical Services and/or Weekend Manager on a.) checking for expired dates prior to administering medication and discarding any expired medications, b.) proper temperature range for medication storage, c.) documenting temperatures on temperature log daily, d.) removing medication from refrigerator if temperature is out of acceptable range and placing in another refrigerator until acceptable range is accomplished, e.) documenting on 24 hour report and maintenance log (checked 5 days per week) at nurses station if temperature is found to be out of acceptable range, f.) weekly cleaning of the refrigerator by 7-3 shift. This education will be presented to newly hired licensed staff during the orientation process.	8/31/12 10/1/2012

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F 431	Continued From page 4 medication cart on the Alzheimers ' unit revealed one bottle of Robafen DM cough syrup with an expiration date of 6/12. Observations of the 300 hall medication cart were made on 8/30/12 with one expired medication found in a drawer. The expired medication was a bottle of Magnesium 500 milligram tablets with an expiration date on the label of 7/12. During the inspection of the 300 hall medication cart, a drawer with nasal medications had a large buildup of powder residue. The drawer containing liquid medications was sticky and coated from spilled liquids. Observations of the medication room on the Alzheimers ' unit on 8/30/12 at 9:20 AM revealed two Fleets enemas with an expiration date of 11/11. Inspection of the refrigerator for medications revealed dried spills and debris inside on the shelves that needed to be cleaned. Expired medication found inside this refrigerator was a multidose vial of Tubersol with an opened date of 7/19/12. Multidose vials of insulin are stored in this refrigerator. Refrigerator temperatures for the month of August were posted on the outside door of the refrigerator. Review of the log revealed the staff was to maintain temperatures between 36 and 46 degrees. Temperatures on the log for August 2012 were found to be at 32 degrees on seven different days and two days of 28 degrees. Interview on 8/30/12 at 4:10 PM with the Maintenance Director revealed he had not been informed of the out of range temperatures of the medication refrigerators.	F 431	#3 A Performance Improvement tool will be completed by the Director of Clincal Service, Unit Manager, and/or Weekend Supervisor daily x 14 days, then 5 times/week x 2 weeks, then 3 times/ week x 2 weeks, then weekly x 2 weeks, then monthly x 10 months to monitor compliance with removal of expired medications, cleanliness of the medication refrigerators and temperature log. #4 Results of the Performance Improvement tool will be presented by the Director of Clinical Services or Administrator to the performance Improvement Committee monthly x 12 months to identify trends and need for further monitoring and/or education.	

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F 431	Continued From page 5 On 8/30/12 at 4:20 PM observations of the main medication room refrigerator revealed incorrect storage of medications. Miacalcin nasal spray was lying flat and should be stored upright. Three unopened packs of Albuterol inhalant .083% for nebulizer breathing treatments were stored in the refrigerator. The manufacturer ' s instructions were to store the inhalant at 36 - 77 degrees. Observation of the thermometer inside the refrigerator during the inspection revealed a temperature of 28 degrees. Multidose vials of insulin are stored in this refrigerator. During the observations on 8/30/12 at 4:20 PM the main medication room refrigerator was in need of cleaning due to dried spills and debris inside on shelves and the door. The temperature log for the month of August 2012 was posted on the outside of the refrigerator door. Review of the temperatures revealed below normal levels during the month of August 2012 of 32, 30, and 29 degrees. Review of medication refrigerator temperature logs for the past three months revealed they had been consistently below 36 degrees ranging from 30 to 34 degrees for the Alzheimers ' unit. The main medication room had temperatures ranging from 28 to 34 degrees. Review of the facility policy and procedures for " Vaccine Storage Handling " with an effective date of 3/12 revealed under #4. If the temperature is outside of the range for specified vaccine, immediate action must be taken to protect the vaccine. Document the action taken. "	F 431		

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F 431	Continued From page 6 Interview on 8/30/12 at 4:28 PM with the Director of Nursing revealed the pharmacy consultant checks for expired medications on each monthly visit. The Housekeeping department was responsible for cleaning of the refrigerators in the medication rooms. Further interview revealed she was not aware the temperatures were below acceptable normal limits. During this interview, the Maintenance Director entered the medication room. The Director of Nursing requested he check the refrigerator temperatures. Second observation of the main medication room refrigerator was made on 8/31/12 at 2:30 PM. The temperature for 8/31/12 was 29 degrees. Interview with the licensed nurse at the time of the observation revealed the 11-7 shift checked the temperatures, and she was not aware the temperature was below the acceptable lower limit.	F 431		
F 441 SS=K	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.	F 441		

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F 441	Continued From page 7 (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 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to disinfect glucometers (a device to obtain blood sugar level) between resident uses in accordance with the manufacturer's recommendations to for 4 of 16 residents (# ' s 24, 13, 104 & 118) who required blood glucose finger sticks. The facility further failed to follow policy and procedure of standard precautions and CDC (Center for Disease Control) guidelines for use of glucometers to reduce the risk of transmission of blood borne pathogens for 16 of 16 residents (#s 9, 13, 24, 26, 40, 54, 58, 60, 64, 77, 104, 108, 109, 116, 117 & 118) receiving blood glucose fingersticks.	F 441	#1 All glucometers were cleaned with EPA approved wipes and EPA approved wipes were made available to allow for cleaning of glucometers between residents. #2 Current residents with orders for blood glucose monitoring in house are at risk for this deficient practice. Current licensed nurses have been re-educated according to the policy and procedure of cleaning and disinfecting the glucometers with an EPA approved wipe before and after each use. Education as to the cleaning and disinfecting procedure for blood glucose meters with return demonstration will be provided during the orientation process for newly hired licensed nurses.	8/30/2012 9/14/2012

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F 441	Continued From page 8 Immediate jeopardy began on 8/29/12 and was removed on 8/31/12. The facility Administrator, Director of Nursing and Corporate Consultant were informed of the immediate jeopardy on 8/29/12 at 12:30 PM. The facility provided a credible allegation of compliance on 8/31/12 at 2:11 PM. Immediate Jeopardy was abated on 8/31/2012 at 5:48 PM. The facility will remain out of compliance at a scope and severity level E (a pattern of no actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete employees training and to monitor its corrective action. The findings included: Review of a facility policy dated 8/04 revised 12/09 revealed instructions to " Disinfect the blood glucose monitor after each use with 1:10 dilution of sodium hypochlorite (bleach) unless the recommendations say otherwise. Note: Do not use alcohol to disinfect the monitor. " A policy dated 3/12 and entitled " Blood Glucose Monitoring " directed staff to: " Cleanse glucometer after each resident use with a dilute bleach solution of 1:10 (one part bleach to 9 parts water) or utilize approved disinfectant wipes per manufacturer ' s instructions. " The Standard Precautions policy dated 3/12 noted, under Resident Care Equipment, " Reusable equipment is not to be used for the care of another resident until it has been cleaned and reprocessed appropriately " and that resident care equipment that is soiled with blood will be handled in a manner that prevents transfer	F 441	#3 Individual glucometers have been purchased and delivered to residents with orders for blood glucose monitoring. These meters have been placed in a lock box in the resident's rooms specific to their bed number. Each new resident requiring blood glucose monitoring and residents newly diagnosed and requiring blood glucose monitoring, will be issued a glucometer by the admitting nurse. The Director of Clinical Services or staff Registered Nurse will monitor staff nurses Performing blood glucose monitoring 3 times/weekly x 4 weeks, then 1 time/ weekly x 4 weeks, and then monthly x 10 months for appropriate cleaning and disinfecting. If any licensed nurse fails to demonstrate appropriate cleaning and disinfecting, they will be taken off the assignment and re-educated with a successful return demonstration prior to continuing on the assignment. #4 The Director of Clinical Services or Administrator will report results of the monitoring to the Performance Improvement Committee to identify trends and need for further Education and/or monitoring monthly x 12 months.	9/24/2012

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F 441	Continued From page 9 of microorganisms to other residents and environments. The manufacturer ' s recommendations were reviewed. Cleaning and Disinfecting Guidelines on page 47 included cleaning and disinfecting can be completed by using a commercially available EPA (Environmental Protection Agency) registered disinfectant detergent or germicide wipe. Observations of four nurses performing blood glucose monitoring on 8/29/12 revealed the multi use glucometers were not disinfected in accordance with manufacturer's recommendations before and after use. 1. On 08/29/12 at 11:40 AM nurse #1 was observed performing a finger stick on resident # 13 to obtain blood for glucose testing (FSBS). The nurse was not observed to disinfect the glucometer prior to performing the finger stick. She placed the blood on a test strip and inserted the strip into a glucometer. Following completion of the procedure, nurse #1 cleaned the glucometer with an alcohol swab. Nurse #1 was questioned as to what the cleaning solution was on the swab and the nurse responded "alcohol" and held up the empty package. After further questioning, the nurse explained that she cleaned the glucometer with alcohol before and after performing a FSBS. She also stated that there was one glucometer that was used for all the residents on the unit who required finger sticks for blood glucose testing. There were no disinfectant wipes observed in the medication cart. When asked if she had ever been trained on cleaning of glucometers she stated she did not remember what cleaning	F 441		

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F 441	Continued From page 10 product to use. 2. At 4:42 PM on 8/29/12 nurse #2 demonstrated the procedure for performing a FSBS. He demonstrated how he inserted a test strip into the glucometer and used a one time use lancet to stick the resident ' s finger, stating he had just completed a FSBS. Nurse #2 was then observed to place the glucometer in the top drawer of the medication cart. He did not demonstrate or explain that he cleaned and disinfected the glucometer before or after use. An interview with nurse #2 at that time revealed he did not disinfect the glucometer because it was disinfected on the night shift. He continued that he did not know what the manufacturer's recommendations were for cleaning and disinfecting the glucometer or where he could find those recommendations. He also did not know what the night shift used to clean the glucometer. Further questioning revealed the nurse was not aware whether the glucometer was cleaned and disinfected prior to use to test the resident ' s FSBS. No disinfectant wipes were observed in the medication cart. The nurse did not know where the information came from regarding night shift cleaning. After leaving the room, the nurse placed the glucometer on the medication cart on top of the basket of the single use lancets. The nurse did not clean or disinfect the glucometer after the FSBS and before returning it to the medication cart. The glucometer screen was visibly soiled with dark colored residue. 3. On 8/29/12 at 4:50PM Nurse #3 was doing a FSBS on resident #24. After leaving the room the nurse placed the glucometer on the medication cart and then on the basket of unused lancets.	F 441		

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	345466	A. BUILDING _____ B. WING _____	C 08/31/2012

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WILLOWBROOK REHABILITATION AND CARE CENTER	333 EAST LEE STREET YADKINVILLE, NC 27055

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F 441	Continued From page 11 The nurse did not clean the glucometer after returning it to the medication cart. Then at 5:00 PM nurse # 3 stated that she was preparing to do another FSBS. The nurse did not clean or disinfect the glucometer and was stopped from performing the FSBS before entering the resident ' s room. Interview with the nurse revealed she usually cleaned the glucometer at the beginning of the shift and she had not cleaned and disinfected it before using it on residents. Nurse # 3 further stated that it was not cleaned or disinfected between residents as the 11-7 shift cleaned the glucometers with a bleach wipe each night. The nurse did not know where this information came from. The nurse confirmed the glucometer needed to be cleaned containing 1:10 bleach solution. The nurse stated she could not remember if she had any in-service training for cleaning and disinfecting glucometers 4. On 8/29/12 at 4:50 PM an interview with nurse #4 revealed she had just completed a finger stick (did not identify the resident), and had already cleaned the glucometer with alcohol. She further stated that the glucometers were cleaned on the 3rd shift and did not know with what they were cleaned. She gathered the one time use lancet, gloves, alcohol pad, and test strips and entered resident #104 ' s room. She completed the finger stick and went back to the cart to clean the glucometers with alcohol and gather supplies for the next finger stick. Nurse #4 entered resident #118 ' s room and completed the finger stick using the same glucometer that she used for Resident # 104. She stated she had always used alcohol to clean the glucometers. On 8/30/12 at 10:50 AM an interview was	F 441		

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F 441	Continued From page 12 conducted with the Administrator, Director of Nursing (DON) and the Regional Director of Clinical Services (DCS). The DON was also the Infection Control Nurse. The Administrator stated she had been in the facility for four days and was not aware of this practice. On 8/30/2012 at 12:05 PM the administrator provided a list of sixteen residents in the facility that received blood glucose monitoring with the glucometers. The DCS stated that an inservice was done in February, 2011 by Nurse #5, who was no longer employed at the facility. She continued the in-service included directives for glucometers to be cleaned between every resident. She added that the staff were in-serviced according to the March, 2012 " Standard Precautions Policy " . She further stated that the night shift was never assigned to clean the glucometers. The DCS stated that they did have one box of 1:10 bleach solution wipes (number of wipes not indicated), EPA approved in the storage room. She further stated the wipes had not been distributed to the nursing units. She did know why they were not distributed. The facility Administrator, Director of Nursing and Corporate Consultant were informed of the immediate jeopardy on 8/29/12 at 12:30 PM. The facility provided a credible allegation of compliance on 8:31/12 at 2:11 PM. Willowbrook Credible Allegation of Compliance glucometer cleaning to provide proper infection control during blood glucose testing.	F 441		

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F 441	Continued From page 13 1. On August 29, 2012 at 4:45pm the Administrator and the Director of Nursing were notified by the Surveyor that the cleaning and disinfecting of the glucometers was not being performed according to CDC guidelines, the Administrator and the Director of Nursing identified a source for obtaining appropriate cleaning and disinfecting wipes. The Medical Records coordinator went to the local hospital to obtain a supply. She returned at 5:45pm with CaviWipes. The label for the CaviWipes states that they are EPA registered #46781-8 to be effective against: Hepatitis B, Hepatitis C, and Human Immunodeficiency Virus, BCG, Staph aureaus, pseudomonas aeruginosa, salmonella enterica, trichophyton mentagrophytes, MRSA, VRE, Staph aureaus with reduced susceptibility to Vancomycin, herpes Simplex Virus types 1 and 2, influenza A2 Virus. At 5:45 pm, she took those to each nurses ' stations and all glucometers were cleaned and disinfected by the staff nurses who were working at that time. Re-education per facility policy, manufacturer ' s recommendations which state " To use a wipe, remove from container and follow product label instructions to disinfect the meter. Take extreme care not to get liquid in the test strip and key code ports of the meter. Many wipes act as both a cleaner and disinfectant, though if blood is visibly present on the meter, two wipes must be used: use one wipe to clean and a second wipe to disinfect " , and the CDC guidelines. The CaviWipes were placed on the carts at 6:00pm after re-education for use during future blood glucose monitoring. 2. Sixteen residents that received blood glucose monitoring were at risk with this deficient	F 441		

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practice. The two RN ' s and one LPN who were working on second shift (3p - 11p) on August 29, 2012 as well the MDS nurse were re-educated about cleaning and disinfecting the glucose monitors prior to and following use at 5:45pm by the Director of Nursing. The two staff RNs who were working second shift on 8/29/2012 re-educated the two staff LPNs who came in to work third shift (11p-7a) at 11 pm. The Director of Nursing verified the understanding of the two third shift LPNs 6:30am on 8/30/12 by having them state the procedure for cleaning and disinfecting the glucometers prior to and following use. At 6:30am 8/30/2012 the Director of Nursing re-educated the 2 RNs and 1 LPN who had arrived to work first shift (7am-3pm) as to the policy of cleaning and disinfecting the glucose monitors prior to and following use. At 2:15pm one staff LPN and then 2:40pm another staff LPN was re-educated. They were observed performing this task at the next scheduled blood glucose testing on their assignments at 4:00pm for the first LPN and 4:15pm for the second LPN by the Director of Nursing. This was all the licensed staff that had worked up to that point. All licensed nursing employees will be re-educated as they arrive for their shifts or in a mandatory staff meeting that is scheduled for Friday, August 31, 2012 at 3:30pm, which ever opportunity presents itself first.

3. The Director of Nursing or staff RN will monitor as to the policy of cleaning and disinfecting the glucose monitors prior to and following use daily for 7 days, choosing a different licensed nurse to observe in that 7 day period. Any new hired licensed nursing staff will be educated as to the cleaning and disinfecting

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procedure for blood glucose monitoring with a retune demonstration prior to performing this procedure. The Director of Nursing or staff RN will monitor staff nurses performing blood glucose monitoring three times weekly for four weeks, one time weekly for four weeks, and monthly thereafter for ten months. If any of the Licensed Nurses demonstrate a deficiency in the practice they will be taken off that assignment and re-educated with a successful return demonstration before they can continue on their assignment. The PI (Process Improvement) committee has met to approve this plan on 8/30/2012 at 5:45pm. The results of the monitoring will be reported to the future PI committee meetings that occur monthly on the third Thursday of each month for review and assessment of effectiveness of the intervention in preventing the deficient practice from reoccurrence. The facility alleges compliance on 8/30/2012 at 6pm.

On 8/31/12 at 1:10 PM an observation of Nurse # 5 utilizing proper technique of cleaning the glucometer was completed. There were no problems or concerns with the cleaning. During the observation nurse #3 came to nurse #5 and asked to borrow the wipes from the cart. She stated she did not have wipes on her cart. At 1:10 PM an observation of nurse # 6 demonstrated the proper technique for disinfecting the glucometers. The nurse stated he disinfects the glucometers before and after each resident ' s finger stick. At 1:15 PM an observation of nurse #7 demonstrated the proper technique for cleaning the glucometers. The nurse left the cart to obtain a container of wipes from another nurse, as she did not have wipes on

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F 441	Continued From page 16 her cart. The nurse explained the steps per the manufacturer ' s recommendations. On 8/31/12 at 2:11 PM observations of the medication carts were done and containers of wipes were on every cart. The facility ' s credible allegation was accepted and the immediate jeopardy was abated on 8/31/2012 at 5:48 PM after validation was completed.	F 441		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III(211) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation on Thursday 11/1/12 at	K 018	The bathroom doors at the nurses station and staff positions barrel bolt latches were replaced. Locks on all staff bathroom doors will be evaluated twice monthly to ensure proper working order with one motion of the hand to open. The Maintenance Director will complete a performance improvement tool 2x monthly for 3 months then monthly x 10 months.	11/5/12

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

Tina Ballard — Executive Director — 11/16/12

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K 018	Continued From page 1 approximately 8:30 AM onward the following was noted: 1) The bathroom doors at the nurse station and staff positions was equipped with barrel bolt latches the required two motions of the hand to open. 42 CFR 483.70(a)	K 018		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Thursday 11/1/12 at approximately 8:30 AM onward the following was noted: 1) The dry storage room in the kitchen at time of survey was found wedged open preventing the door from closing.	K 029	The wedge in the dry storage room in the kitchen that was preventing the door from closing was removed. A magnetic door opener was installed in the dry storage area in the kitchen. The Maintenance Director will complete a performance improvement tool 2x monthly for 3 months then monthly x 10 months to ensure the dry storage area door is not propped open with a wedge.	11/2/12 11/2/12
K 052 SS=D	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance	K 052		

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K 052	Continued From page 2 with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation on Thursday 11/1/12 at approximately 8:30 AM onward the following was noted: 1) By observation there was not a visual/audible trouble signal at the Fire Alarm Control Panel (FACP) with loss of telephone line connection.	K 052	The automatic dialer was replaced so as to have a visual/audible trouble signal at the fire alarm panel with loss of telephone connection. The Maintenance Director will evalutate the visual /audible trouble signal At the fire panel weekly x 4 weeks, then monthly x 10 Months. The Maintenance Director will complete a performance improvement tool weekly x 4 weeks, then monthly x 10 months to ensure the visual/audible trouble signal is working properly.	11/2/12
K 054 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation on Thursday 11/1/12 at approximately 8:30 AM onward the following was noted: 1) The smoke duct detectors located in the HVAC units in the attic were not maintained clean	K 054	The smoke duct detectors located in the HVAC units in the attic were cleaned. The Maintenance Director will inspect and complete a performance improvement tool on the smoke duct detectors 1x monthly x10 months for cleanliness and to ensure proper working order.	11/1/12

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K 054	Continued From page 3 and in good operating condition. 42 CFR 483.70(a)	K 054		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on Thursday 11/1/12 at approximately 8:30 AM onward the following was noted: 1) Upon review of the sprinkler inspection documentation dated 10/19/12 there are deficiencies noted in the report that have not been corrected. 2) A five year internal inspection of the sprinkler system is due. 3) Upon review sprinkler documentation a full flow test for the sprinkler system has not been conducted in the last three year.	K 056	The corroded sprinkler heads identified in the sprinkler inspection will be replaced. The Maintenance Director will inspect and complete a performance improvement tool on the sprinklers 1x monthly x 10 months for corrosiveness. The test drain valve for the sprinkler system as identified on the Sprinkler inspection will be replaced and ensure the drain is not stopped up. The Maintenance Director will inspect and complete a performance improvement tool on the test drain quarterly with the drain inspection and ensure the drain is opened for proper flow.	12/31/12 12/31/12
K 072	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD	K 072		

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K 072 SS=F	Continued From page 4 Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation on Thursday 11/1/12 at approximately 8:30 AM onward the following was noted: 1) Through-out the facility there was storage on the exit corridors. (hoyer lifts, gerri chairs, wheelchairs, transfer chairs, soiled and clean linen carts.) 42 CFR 483.70(a)	K 072	K056 The five year internal inspection of the sprinkler system will be completed. The Maintenance Director will schedule the next five year internal inspection of sprinkler system in our TELS system to ensure it is completed. A full flow test for the sprinkler system will be conducted The Maintenance Director will schedule the next year's full flow test for the sprinkler system in our TELS system to ensure it is completed.	12/31/12 12/31/12
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation on Thursday 11/1/12 at approximately 8:30 AM onward the following was	K 144	K072 All storage was removed on the exit corridors. All staff are educated on not storing items in the exit corridors.	11/2/12 11/21/12

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K 144	Continued From page 5 noted: 1) The generator annunicator panel at the time of the survey indicated a low water temperature on the emergency generator at the time of the survey. The low water temperature was verified upon testing the generator. The low water alarm went off after the generator warmed up and came back on after the generator cooled back down. 42 CFR 483.70(a)	K 144	K072 The Maintenance Director, Executive Director, or Director of Clinical Services will inspect that there are no items being stored in the exit corridors daily x 2weeks, then 2 x weekly for 2 weeks, then monthly x 10 months. The Maintenance Director, Executive Director or Director of Clinical Services will complete a performance improvement tool daily x 2 weeks, then 2x weekly x 2 weeks, then monthly x 10 months. K144 The low water temperature that was annunicated on the emergency generator has been repaired. The Maintenance Director will inspect the water temperature gauge on the emergency generator daily x 2 weeks, then 2x weekly x 2 weeks, then monthly x 10 months. The Maintenance Director will complete a performance improvement tool daily x 2 weeks, then 2x weekly x 2 weeks, then monthly x 10 months.	11/8/12