STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

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F 000	INITIAL COMMENTS No deficienies were cited as result of the complaint investigation. Event ID #RCGW11.	F 000		
F 441 SS=E	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 Personnel must handle, store, process and	F 441		9/5/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/11/2014

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F 441	Continued From page 1 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to disinfect 2 blood glucose meter's according to manufacturer's recommendations for 2 of 2 residents observed for a blood sugar check (Resident's #33 and #97). The findings included: A review of the facility policy and procedure titled Blood Sampling - Capillary (Finger Sticks) with a revised date of April 2007 indicated the following policy statement: The purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to prevent transmission of blood borne diseases to residents and employees. The procedure for disinfection under #8 was following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices with Dispatch or Clorox bleach health care wipes after each use. Let dry 1 minute. A review of the instructions provided by the manufacturer of the disinfectant germicidal disposable wipes indicated an overall dry time of 1 minute to disinfect microorganisms. 1. On 08/20/14 at 4:59 PM during observations of medication administration Nurse #1 removed a blood glucose meter from the medication cart and wiped it with a disinfectant wipe, gathered her	F 441	This Plan of Correction constitutes this facility□'s written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law. F441 A. Corrective actions taken for resident found to have been affected by alleged deficient practice as listed: On 8/22/14, the Director of Nursing conducted one-on-one infection control training with the Nurses for resident #33 and resident #97 on proper disinfection of the glucometers. The Nurses were trained using the glucometer device manufacturer approved disinfectant wipe and timing the 1 minute wet time required for disinfection and then allowing the device to dry. B. Corrective actions taken for residents having the potential to be affected by the same alleged deficient practice: The DON and ADON implemented infection control in-service education and for all nursing personnel who perform finger stick blood sampling. This training began on 8/22/14. The DON and ADON	

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F 441	Continued From page 2 supplies and entered the Resident #33's room to perform the finger stick. The meter was visibly wet at the time of the finger stick. During an interview on 08/20/14 at 5:05 PM with Nurse #1 she stated she used a disinfectant wipe to clean the blood glucose meter before and after resident use. Nurse #1 stated she was not aware of a 1 minute dry time after cleaning the meter before using the meter on another resident. 2. On 08/21/14 at 11:35 AM during observations of medication administration Nurse #3 removed the blood glucose meter from the medication cart drawer and cleaned it with a disinfectant wipe and took the meter to the Resident #97's room and performed the finger stick. The meter was visibly wet at the time of the stick. During an interview on 08/21/14 at 11:41 AM with Nurse #3 she stated she cleaned the blood glucose meter with a disinfectant wipe before and after each use. Nurse #2 stated she did not know there was dry time of 1 minute before using the meter after cleaning. An interview conducted on 08/21/14 at 4:34 PM with the Director of Nursing (DON) revealed it was her expectation for the staff to clean and disinfect the blood glucose monitors per facility and manufacturer recommendations of the disinfectant wipes and to let the meter air dry for 1 minute before use. The DON stated the minute should be timed by a watch or clock.	F 441	have trained the staff according to the glucometer manufacturer's procedure for disinfecting the device and per the approved disinfectant wipe manufacturer's instructions ensuring timing of required 1 minute wet time then and air drying the device before use or storage. C. Measures taken and systems changed to prevent repeat of alleged deficient practice: Infection Control Action Plan implemented as follows: 1. A new Glucometer Disinfection Training & Competency Evaluation tool was developed and implemented for initial and ongoing training, to ensure all users receive uniform training on correct disinfection process following the device and disinfectant wipe manufacturer's recommendations. 2. Timers placed on all medication carts to assure access to a device for timing the required 1 minute wet time of the glucometer to achieve proper disinfection per the disinfectant wipe instructions, then allowing the unit to dry before use or storage. 3. The DON and/or ADON will conduct weekly random performance improvement observation audits of the staff during the glucometer disinfection process. The benchmark for competency was set by the QAPI comittee at 100% accuracy. Anyone observed with less than 100% accuracy will receive on the spot re-training and will be observed for 3 additional concurrent disinfection procedures to ensure competency. Observation audits began on	

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F 441	Continued From page 3	F 441	9/1/14 of 10 glucometer disinfection procedures per week. Audits will continue at 10 per week for a minumum of 8 weeks. If 100% compliance is maintained for 8 weeks, the audit will decrease to 5 times per week for an additional 4 months. D. Facility Monitoring to Ensure Sustained Compliance: This Performance Improvement Project was initiated by the Quality Assurance Performance Improvement committee. It is supervised by the DON and implemented as follows: The DON will review the results of above stated glucometer disinfection surveillance audits weekly. The results of these competency audits and any identified trends or concerns will be reported by the DON or ADON to the QAPI committee monthly for a period of 6 months. Data will be collected and analyzed beginning September 1, 2014 through Feb 28, 2015. The QAPI committee will determine if this Performance Improvement Action Plan requires further intervention or systemic changes to assure sustained compliance with F 441.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the	F 520		9/9/14

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F 520	Continued From page 4 facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in March of 2012. This was for one recited deficiency which was originally cited in March 2012 on a Recertification survey and subsequently recited in May of 2013 and on the current recertification survey. The deficiency was in the area of infection control. The continued failure of the facility during three federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included:	F 520	A. Corrective actions taken for resident found to have been affected by alleged deficient practice as listed: No residents were affected by the alleged deficient practice however the following actions were implemented for the cross reference by the surveyor to the F441 Infection Control citation: The DON provided one-on-one education on the proper disinfection procedure of the glucometers with the Nurses for resident #33 and resident #97 on 8/22/14. B. Corrective actions taken for residents having the potential to be affected by the same alleged deficient practice:	

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F 520	Continued From page 5 This tag is cross referred to: F441: Infection Control: Based on observations, record reviews and staff interviews the facility failed to disinfect 2 blood glucose meters according to manufacturer's recommendations for 2 of 2 residents observed for a blood sugar check (Resident's #33 and #97). During the recertification survey of 03/30/12 the facility was cited for failure to disinfect blood glucose meters after use between residents and failed to remove gloves and wash hands after incontinence care. During the recertification survey on 05/23/13 the facility failed to maintain infection control practices regarding soiled linen and cleaning of environmental surfaces during personal care. On the current recertification survey F441 was again recited for failing to disinfect blood glucose meters according to manufacturer's recommendations. During an interview on 08/21/14 at 4:34 PM the Director of Nursing (DON) revealed she routinely attended the Quality Assessment and Assurance committee meetings. She explained an infection control report was given at each committee meeting regarding infections in the facility but they had not discussed cleaning of glucometers according to manufacturer's recommendations. During an interview on 08/21/14 at 5:00 PM the Administrator stated the Quality Assessment and Assurance committee had worked on plans of correction related to the specific deficiency for infection control that was cited at the last recertification survey related to handling of soiled linens and cleaning of environmental surfaces	F 520	New Infection Control Performance Improvement Project was initiated by the QAPI committee on 8/26/14. A revised training competency was written and the Action Plan was implemented by the DON and ADON. New hands on glucometer disinfection demonstrations of competency are required for all staff responsible for using glucometers. The disinfection process is in accordance with the device and the disinfectant manufacturer□s recommendations. C. Measures taken and systems changed to prevent repeat of alleged deficient practice: The QAPI committee met on 8/26/14 and performed Root Cause Analysis to determine why previous compliance was not sustained in the area of glucometer disinfection. As a result of the findings of the RCA, an immediate Performance Improvement Action Plan was developed. The Action Plan was implemented by the DON and ADON to include the revision of the initial staff training, annual competency evaluations, and infection control surveillance audits of the glucometer disinfection procedures in accordance to the device and disinfectant manufacturer□s recommendations. The weekly surveillance audits began on 9/1/14 and will continue through 2/28/14, as detailed in F441. The benchmark for this audit is 100% accuracy of disinfection process by each individual observed. Anyone who demonstrates less than the benchmark will receive immediate re-education and repeat competency	

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F 520	Continued From page 6 during care but they had not identified a problem with disinfection of glucometers. She stated she was not aware there was a problem with disinfection of glucometers or that nursing staff were not following the manufacturer's recommendations.	F 520	evaluation. D. Facility Monitoring to Ensure Sustained Compliance: This Infection Control Performance Improvement Project for glucometer disinfection was initiated by the Quality Assurance Performance Improvement committee. It is supervised by the DON, and has been implemented as follows: The DON or ADON will present the infection control surveillance data collected from this performance improvement project at the monthly QAPI meeting. The committee will review the data monthly for a period of 6 months and recommend any necesary interventions to ensure the action plan is effective in achieving and maintaining the benchmark and that the deficient practice is corrected and compliance is maintained. The QAPI committee will utilize the OSCAR data to take a proactive approach in avoiding repeat citations. The committee will regularly review past quality deficiencies and implement periodic surveillance audits and quality reviews to ensure the previous plans of correction remain effective and compliance is maintained in effort to prevent repeat citations.	