STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345525	A. BUILDING _____ B. WING _____	02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS OF TAYLOR GLEN RET COM	3700 TAYLOR GLEN LANE CONCORD, NC 28027

(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 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 Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		3/2/16

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

Electronically Signed | 03/02/2016

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 441	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility policy the facility failed to disinfect 2 glucometers prior to use for 2 of 2 sampled residents observed getting blood glucose checks. (Resident #3 and Resident #5) The findings included: The facility policy effective July 30, 2011, entitled, " Blood Glucose Monitoring " read in part : Procedure-The Blood Glucose Monitoring Device will be disinfected both prior to testing and post testing per the FDA (Food Drug Administration) recommended cleaning solution or manufacturer suggested guidelines. On 2/17/15 at 8:35 AM Nurse #1 was preparing to perform a blood glucose check on Resident #3 and it was observed that 2 glucometers were stored together uncovered in the medication cart drawer. Each glucometer was labeled with a resident name. Nurse #1 removed the glucometer for Resident #3, donned gloves and performed the blood glucose check without disinfecting the glucometer prior to use. Upon completion of the blood glucose check, Nurse #1 cleaned the glucometer with a disposable germicidal wipe, wrapped the glucometer in the wipe and returned it to the medication cart drawer. Nurse #1 stepped away from the medication cart and washed her hands. On 2/17/16 at 8:45 AM Nurse #1 was preparing to perform a blood glucose check on Resident #5. Nurse #1 removed the glucometer for Resident #5 from the medication cart drawer, donned gloves and performed the blood glucose check	F 441	When the deficient practice was discovered, the nurse was in-serviced on the proper way, as defined by policy, to clean the glucometer. The review of the procedue with the licensed nurse was completed by the Director of Nursing. Completion Date: February 17, 2016 The Director of Nursing scheduled immediate in-services to review the policy and procedure for the cleaning of the glucometer. Each licensed nurse was scheduled for this review. The in-services were completed. Completion Date: February 19, 2016 The RN Supervisor checklist has been revised to include an audit that glucometers have been properly cleaned as defined by facility policy and procedure. This audit is completed daily, per shift, by each RN Supervisor. The audits are forwarded to the Director of Nursing. The Director Nursing reviews these daily and will monitor for compliance. Completion Date: February 22, 2016 The care plan team meets weekly. The care plan team consists of the Director of Nursing, Director of Social Services, Director of Dining Services, activity assistant, therapy and Administrator. During that meeting, the audit results will be reviewed and discussed. The results	

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F 441	Continued From page 2 without disinfecting the glucometer prior to use. Upon completion of the blood glucose check, Nurse #1 cleaned the glucometer with a disposable germicidal wipe, wrapped the glucometer in the wipe and returned it to the medication cart drawer. An interview with Nurse #1 on 2/17/16 at 8:50 AM revealed that she normally disinfects the glucometers only after use, if that is wrong she will change the way she is doing it. During an interview with the Director of Nurses on 2/17/16 at 9:30 AM indicated that her expectations were that the glucometers were to be cleaned before and after use and according to the policy.	F 441	will be included in the monthly Quality Assurance meeting for one year from date of survey. Completion Date: March 3, 2016	