STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345471	A. BUILDING _____ B. WING _____	05/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MECKLENBURG HEALTH & REHABILITATION CENTER	2415 SANDY PORTER ROAD CHARLOTTE, NC 28273

(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 On May 21 - 25, 2018, The Division of Health Service Regulation, Nursing Home, Licensure & Certification Section conducted an annual recertification survey. Immediate Jeopardy was identified at: CFR 483.35 at tag F726 at a scope and severity of K CFR 483.70 at tag F835 at a scope and severity of K CFR 483.80 at tag F880 at a scope and severity of K Immediate Jeopardy began on 5/23/18 and was removed on 5/25/18. An extended survey was completed.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:	F 636		6/25/18

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

Electronically Signed | 06/18/2018

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 636	Continued From page 1 (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or	F 636		

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F 636	Continued From page 2 mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to complete an admission Minimum Data Set (MDS) within 14 days of admission for 1 of 3 sampled residents reviewed for comprehensive assessments (Resident #177). The findings included: Resident #177 was admitted to the facility from an acute hospitalization on 4/27/18 with diagnoses that included multiple fractures of the ribs, hepatic failure, gout, acute kidney failure, and hypertension. A review of the Minimum Data Set (MDS) assessment records for Resident #177 in his electronic medical record revealed the admission MDS assessment had an Assessment Reference Date (ARD) of 5/10/18. Further review of the electronic medical record revealed Resident #177's admission MDS assessment had not been completed. An interview on 5/25/18 at 1:17 pm with the MDS Coordinator revealed Resident #177's comprehensive assessment had not been completed due to not having the assistance from	F 636	This allegation of compliance is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following credible allegations constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be completed by the dates indicated. F636 The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. The facility failed to ensure timely completion of the Admission Assessment with ARD of 5-10-18 for resident #177. The assessment had not been completed as of 5-25-18. Analysis of the processes that led to the late assessment revealed that the MDS coordinator was unable to keep up with the assessment volume independently. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. The MDSC Consultant provided education to the MDS Coordinator and IDT on timely completion of Admission Assessment, per the RAI Manual, completed by 6-22-18.	

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F 636	Continued From page 3 an unfilled MDS position. The MDS Coordinator stated she had been doing the best she could and had hoped to have Resident #177's assessment completed on Monday, 5/28/18. An interview on 5/25/18 at 11:07 am with the Administrator revealed it was her expectation for the comprehensive assessments to be completed on time. She indicated the Staff Development Coordinator had been on vacation and would be returning to the facility to work in the MDS Department.	F 636	The MDS Admission Assessment for resident #177 was completed on 5-28-18. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The MDS Consultant or designee will audit 5 residents Admission Assessments for timely completion 1 time a week for 4 weeks, 2 times a month for 1 month, and monthly for 4 months. Any comprehensive assessments not completed within 14 days of the ARD will be immediately corrected with coaching/discipline as needed to the MDS Coordinator. Results of the audits will be presented to be reviewed at the facility QAPI meeting. The title of the person responsible for implementing the acceptable plan of correction. The MDS Consultant is responsible for implementing the acceptable plan of correction by 6-25-18.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		6/25/18

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F 657	Continued From page 4 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews the facility failed to revise/ update a care plan in the area of increase/ prevent decrease in Range of Motion (ROM)/ Mobility for 1 of 4 residents (Resident #50) for review of care plan timing and revision. Findings included: Resident #50 was admitted to the facility on 10/02/2015. Diagnoses included dysphagia, hemiplegia, unspecified lack of coordination, muscle weakness, hemiplegia and hemiparesis affecting left dominant side, chronic pain, peripheral vascular disease and hypertension. Review of the care plan dated 3/5/2015 revealed	F 657	The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. The facility failed to revise/update a resident's care plan in the area of range of motion and the application of an ankle foot orthotic. Analysis of the process that led to the deficient practice revealed that the therapy department had not communicated the recommendation for the passive range of motion nor the orthotic to the MDS and nursing staff. Resident #50□s care plan was updated on 6-15-18 to include his orthotic. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. The Director of Rehabilitation provided education to the therapy staff on	

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F 657	Continued From page 5 a problem/ onset for Resident #50 related to limited physical mobility related to stroke. No intervention identified for the left ankle/ foot brace to be applied. Review of the quarterly Minimum Data Set (MDS) dated 4/9/2018 revealed that Resident #50 had moderate cognitive impairment. Resident #50 required extensive assistance with bed mobility, transfers, total dependence for toileting and supervision for eating. Resident #50 was coded for impairment to the upper and lower extremities. Review of the Physical Therapy Discharge Summary dated 4/17/2018 revealed a summary that read in part, patient appropriate for discharge to restorative nursing program for left lower extremity passive range of motion and daily donning/ doffing of left ankle foot orthotic (AFO). Discharge status and recommendations were for Resident #50 to receive restorative nursing program/ functional maintenance program that included application of the left AFO 4 to 8 hours per day. An observation on 5/21/2018 at 5:16pm revealed Resident #50 in bed resting with left foot bent to the right. A blue boot was in the corner of Resident #50's room. An observation on 5/23/2018 at 1:20pm revealed Resident #50 having lunch in his bed. His left foot was propped on a pillow bent to the right. Blue boot observed in the corner.	F 657	communicating recommendations for orthotics, braces, and splints to the MDS and Nursing teams and not just documenting them; completed by 6-22-18. The facility Director of Rehabilitation will be responsible for printing all therapy restorative recommendations for orthotics, braces, and splints and bringing them to the morning stand-up meeting for review by the nursing team. Nursing administration will assess the recommendation from therapy and place on the care plan for implementation by nursing staff. The MDS Coordinator will review the care plan for updates/accuracy with each MDS completion. The MDS Consultant provided education to the MDS Coordinators and Nursing Administration that care plans need to reflect current resident status and should be reviewed with each quarterly or annual assessment; completed by 6-22-18. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The MDS Consultant or designee will audit therapy recommendations for restorative programs for orthotics, braces, and splints on residents discharged from therapy and remaining in the facility. The audit will review any residents discharged since the last audit up to a random sample of 5 resident care plans. The audit will assess if any restorative programs were recommended and are updated/accurate on the current care plan, for 1 time per week for 4 weeks, 2	

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F 657	Continued From page 6 An interview on 5/24/2018 at 9:20am with the Interim Director of Nursing revealed that she had not seen the boot applied to Resident #50's foot. An interview with the MDS nurse on 5/24/2018 at 9:47am revealed that she completes the comprehensive assessments and care plans. The MDS nurse further revealed that she was by herself and trying to keep up. The MDS nurse did not identify who was responsible for quarterly assessments and care plans. An interview on 5/25/2018 at 10:00am with the Rehab Manager revealed that she recalled Resident #50 receiving physical therapy from March to April. Physical therapy worked on transfers, bed mobility with proper hand and foot placement. The Rehab Manager verbalized that Resident #50 had a left foot/ankle brace that should be worn 4 to 8 hours per day. An observation with the Rehab Manager revealed that the blue boot was the left foot/ankle brace. An interview on 5/25/2018 at 10:47am with Resident #50's regularly assigned nurse aide revealed the resident does not wear that boot. The nurse aide further stated that she did not receive education regarding the boot application from therapy. The nurse aide verbalized that she would put the boot on if she knew about it. The nurse aide did indicate that she offers passive range of motion and the resident declines. An interview on 5/25/2018 at 10:50am with	F 657	times a month for 1 month, and monthly for 4 months. Any issues identified on the audits will be immediately corrected with coaching/discipline as needed to the MDS Coordinator. Results of the audits will be presented in the quarterly QAPI meeting. The title of the person responsible for implementing the acceptable plan of correction. The MDS Consultant is responsible for implementing the acceptable plan of correction by 6-25-18.	

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F 657	Continued From page 7 Resident #50 revealed that he has not worn the boot. Resident #50 indicated that he would wear the boot if staff applied it. An interview with the Administrator on 5/25/2018 at 11:51am revealed that her expectation regarding care plan revision and updating care plans were for the MDS nurse to update care plans with the MDS schedule or as needed.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews the facility failed to apply a left ankle/ foot orthotic (AFO) recommended by physical therapy to be worn daily for up to 8 hours for 1 of 4 residents	F 688	The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. The facility failed to ensure the application of an ankle foot orthotic. Analysis of the	6/25/18

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F 688	Continued From page 8 (Resident #50) observed for range of motion. Findings included: Resident #50 was admitted to the facility on 10/02/2015. Diagnoses included dysphagia, unspecified lack of coordination, muscle weakness, hemiplegia and hemiparesis affecting left dominant side, chronic pain, peripheral vascular disease and hypertension. Review of the care plan dated 3/5/2015 revealed a problem for Resident #50 related to limited physical mobility related to stroke. The goal identified for Resident #50 included that he would remain free of complications related to immobility, including contractures. The interventions included application of splint to left arm as ordered for 4 to 8 hours a day and resident to be seen by therapy. No intervention was identified for the left ankle/ foot brace. Review of the quarterly Minimum Data Set (MDS) dated 4/9/2018 revealed that Resident #50 had moderate cognitive impairment. Resident #50 required extensive assistance with activities of daily living (ADLs). Resident #50 was coded for impairment to the upper and lower extremities. Resident #50 was coded as receiving physical therapy services. Review of the Physical Therapy Discharge Summary dated 4/17/2018 revealed a summary that read in part, patient appropriate for discharge	F 688	process that led to the deficient practice revealed that the therapy department had not communicated the recommendation for the passive range of motion nor the orthotic to the nursing staff. Resident #50□s passive range of motion and orthotic needs were added to the restorative program and the care plan on 6-15-18 for C.N.A. implementation and documentation. The facility had already identified and initiated a performance improvement plan for restorative programs. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. The facility will continue with the previously initiated performance improvement plan to improve restorative programming in the facility. The Director of Rehabilitation provided education to the therapy staff on communicating recommendations to the Nursing team and not just documenting them; completed by 6-22-18. The facility Director of Rehabilitation will be responsible for printing all therapy restorative recommendations and bringing them to the morning stand-up meeting for review by the nursing team. Nursing administration will assess the recommendation from therapy and will determine which programs to implement and place on the care plan for staff implementation. Nursing staff (nurses and aides) were provided in-service education on the facility restorative program, including documentation, by the Director of Nursing (DON); completed by	

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F 688	Continued From page 9 to restorative nursing program for left lower extremity passive range of motion and daily donning/ doffing of left ankle foot orthotic (AFO). Discharge status and recommendations were for Resident #50 to receive restorative nursing program/ functional maintenance program that included application of the left AFO 4 to 8 hours per day. Review of the Therapy Restorative Nursing Referral dated 4/17/2018 revealed that Resident #50 had a goal of splint application to maintain correct alignment to the left hand/ wrist and the left ankle/foot. Splint to be applied 4 to 8 hours per day in the mornings. An observation on 5/21/2018 at 5:16pm revealed Resident #50 in bed resting with left foot bent to the right. A blue boot was in the corner of Resident #50's room. An observation on 5/22/2018 at 4:36pm revealed a blue boot in the corner of Resident #50's room. An observation on 5/23/2018 at 1:20pm revealed Resident #50 having lunch in his bed. His left foot was propped on a pillow bent to the right. Blue boot observed in the corner. An interview on 5/24/2018 at 9:20am with the Interim Director of Nursing revealed that she had not seen the boot on Resident #50's foot.	F 688	6/22/18. Resident charts were audited for therapy restorative referrals on 6/15/18. Facility residents identified for restorative programs had the program updated in their care plan on 6-18-18. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. Nursing administration will audit resident charts for Therapy Restorative Nursing Referral forms on residents discharged from therapy and remaining in the facility. The audit will review any residents discharged since the last audit up to a random sample of 5 resident care plans. The audit will assess if any restorative programs were recommended and are on the current care plan for staff implementation, for 1 time per week for 4 weeks, 2 times a month for 1 month, and monthly for 4 months. Any issues identified on the audits will be immediately corrected and any staff not implementing restorative programs will receive progressive discipline. Results of the audits will be presented in the quarterly QAPI meeting. The title of the person responsible for implementing the acceptable plan of correction. The Rehabilitation Director and DON are responsible for implementing the acceptable plan of correction by 6-25-18.	

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F 688	Continued From page 10 An interview on 5/25/2018 at 10:00am with the Rehab Manager revealed that she recalled Resident #50 receiving physical therapy from March to April. Physical therapy worked on transfers, bed mobility with proper hand and foot placement. The Rehab Manager verbalized that Resident #50 had a left foot/ankle brace that should be worn 4 to 8 hours per day. An observation with the Rehab Manager and surveyor revealed that the AFO was the blue boot in the corner of the resident room on the floor. An interview on 5/25/2018 at 10:47am with Resident #50's regularly assigned nurse aide revealed the resident does not wear that boot. The nurse aide further stated that she did not receive education regarding the boot application from therapy. The nurse aide verbalized that she would put the boot on if she knew about it. The nurse aide indicated that she offered passive range of motion to the resident and the resident declines. An interview on 5/25/2018 at 10:50am with Resident #50 revealed that he had not worn the boot. Resident #50 indicated that he would wear the boot if staff applied it. An interview on 5/25/2018 at 11:51am with the Administrator revealed that her expectation regarding splint application and performing passive range of motion was that the information would be included in the resident's care plan, executed by the nurse aide, and overseen by the unit manager.	F 688		

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F 726	Continued From page 11	F 726		
F 726 SS=K	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, physician, and staff interviews the facility failed to provide training to 3 of 4 facility nurses (Nurse #2, and Nurse #3) on how to disinfect a glucometer (a	F 726	The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. " The facility will continue the plan of	6/25/18

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F 726	Continued From page 12 device used to test glucose level in the blood) that was shared among 5 residents and on how to dispose of a used sample test strip (Nurse #1) to avoid cross contamination of the residents' environment and to prevent disease transmission. The failed practice had the potential to affect 6 of 30 residents who had physician ordered blood glucose monitoring in the facility by exposing the residents to the risk for cross-contamination of potential bloodborne pathogens (Resident #47, Resident 73, Resident #72, Resident #67, Resident #74, and Resident #223). Immediate Jeopardy began on 5/23/18 when lack of training resulted in Nurse #1 transporting a blood sample test strip used on Resident #36 during blood glucose monitoring in his right scrub top pocket commingled with clean and dirty supplies that included a nebulizer treatment that would be later administered to Resident #47. On a separate medication pass observation Nurse #2 was observed not disinfecting a shared glucometer after each use to collect blood samples for blood glucose readings from 5 residents (Resident 73, Resident #72, Resident #67, Resident #74, and Resident #223). Immediate jeopardy was removed on 5/25/18 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (pattern with no actual harm with potential of more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to disinfecting glucometers, transporting supplies exposed to blood, and preventing transmission of bloodborne	F 726	correction initiated on 5-23-18. " As part of the root cause analysis of the deficient practice by the administrator, a review and analysis of the facility orientation for licensed nursing staff was conducted; it was noted that there was not a specific skills validation for the competency of nursing staff in cleaning glucometers and hand washing signed as part of their blood borne pathogens training. When the staff development coordinator was questioned, she stated that she gave the forms to the staff and expected them to complete them with their training nurse and return them to her but did not validate their completion. " The root cause analysis also revealed that the Director of Nursing was not evaluating competency on newly hired nurses prior to a nurse being released to floor. " During the analysis of the deficient practice of Nurse #1, the nurse admitted to not following proper procedure by placing the glucometer strip for Resident #36 in his scrub pocket comingled with supplies for Resident #47. " Nurse #1 was pulled off the cart immediately to discuss the deficient practice for infection control and possible cross contamination. Nurse #1 was then sent home and no longer is an employee of the facility. " No other nurses were identified as placing supplies with potential blood borne pathogens comingled into scrub pockets. " Nurse #2 did not clean the glucometer after the accucheck on Resident #73 and proceeded to perform accuchecks on	

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F 726	Continued From page 13 pathogens. The findings included: A review of a facility policy for Exposure Control Policies and Procedures dated 5/26/2016, titled, "Training Records" read in part, 1. The Health and Rehabilitation Center maintains records which include the following information: a. Names of Employees b. Dates of the training sessions c. Contents or a summary of the training session d. Names and qualifications of persons conducting the training e. Names and job titles of all persons attending 2. Bloodborne Pathogens Orientation Acknowledgement and the Employee Record of annual Administration (OSHA) Medical record which is maintained as confidential by the Staff Development Coordinator. 3. All Health and Rehabilitation Center training records regarding bloodborne pathogens are available upon request to employees, employee representatives, the Assistant Secretary, and the Director of OSHA, for examination and copying in accordance with 29 CFR 1910.20. A review of a facility policy for Patient Care Equipment dated 12/26/17, Section 13, titled,	F 726	residents # 72, 74, 67, 223. Nurse #2 was also observed not sanitizing her hands between glove changes. Nurse #2 was immediately removed from patient care, and in-serviced. Nurse #2 did not return to patient care until a return demonstration was validated by an RN. Nurse #2 is no longer employed by the facility and has been reported to the board of nursing. " Nurse #3 expressed lack of knowledge by instructing Nurse #2 to disinfect the glucometer by using the wrong cleaning supply by using alcohol wipes after the completion of an accucheck. Nurse #3 was in-serviced immediately and returned to patient care as soon as she verbalized correct cleaning procedures, return demonstration, and a quiz following the education to determine knowledge retention. " During the analysis of the deficient practice of Nurses #2 & #3, the nurses expressed to the direct supervisor that they knew to clean the glucometers but also thought alcohol wipes were an appropriate alternative for cleaning. After receiving the first in-service education on 5-23-18, Nurse #3 was unable to verbalize the correct process when questioned by the surveyor. Nurse # 3 then received additional training with return demonstration conducted by the Regional Nurse Consultant on 5/23/18. Nurse #2 admitted that she knew she needed to disinfect the glucometers but did not.	

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F 726	Continued From page 14 "Glucometers" read in part, Clean the outside of the meter using a lint-free cloth. Clean in accordance with manufacturer's recommendation. A review of the manufacturer's guidelines noted in the User Instruction Manual revised on 1/17, titled, "Maintenance, Cleaning and Disinfecting Guidelines" read in part, Healthcare professionals should wear gloves when cleaning the meter. Wash hands after taking off gloves. Contact with blood presents a potential infection risk. We suggest cleaning and disinfecting the meter between patient use. Cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant detergent or germicide wipe. A review of the PDI Sani Cloth Bleach Germicidal Disposable Wipe manufacturer guidelines read in part, to disinfect: unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full 4 minutes. Use an additional wipe(s) if needed to assure continuous 4 minute wet contact time. A review of a facility policy for Handwashing Requirements dated 12/26/17, Section A, titled, "Hand Hygiene" read in part, situations that require hand hygiene: before and after performing any invasive procedure (e.g. fingerstick blood sampling). A review of a facility policy for Infection Control Policies and procedures dated 2/01/15, Section	F 726	The procedure for implementing the acceptable plan of correction for the specific deficiency cited. " The facility will continue the plan of correction initiated on 5-23-18. " Facility nursing staff are being in-serviced beginning on 5-23-18 on the policy on Patient Care Equipment including: use of PDI Sani-Wipes, and wet time. Facility nursing staff are being in-serviced beginning on 5-23-18 on the policy Handwashing Requirements. Facility nursing staff also acknowledged by signature the understanding of transmission precautions and that proper hand washing and glucometer disinfecting was required to prevent the transmission of blood borne pathogens. Education was provided by the Regional Nurse Consultant to the Director of Nursing and Unit Managers with return demonstration and then Education was provided by DON, Unit managers, and Regional Nurse Consultant to the facility licensed nursing staff. New hires will be educated during general orientation by a member of nursing administration. All nursing staff will be in-serviced before returning to work. " Facility medication carts were provided with a job aide describing the steps to cleaning a glucometer as a visual reference for the staff on the competent technique to use on 5-23-18 by the Regional Nurse Consultant. " Beginning 5-24-18, current nurses will have skills validation sheets completed on Glucose Monitor Cleaning/Disinfecting and Blood Borne Pathogens. All new	

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F 726	Continued From page 15 C, 2., read in part, Unit Managers assure that staff follows infection control procedures to maintain patient safety. Section C, 6., Equipment will be disposed of or properly disinfected. An observation on 5/23/18 at 9:00am on Hall 200 for cart #2 revealed Nurse #1 placed a nebulizer treatment for Resident #47 in the right pocket of his scrub's. On 5/23/18 at 9:01am Nurse #1 was observed to gather alcohol wipes, gloves, a lancet, glucometer, insulin syringe, a vial of Humalog (insulin used to treat diabetes), a Levemir Flexpen (insulin), and pen needle and then placed the supplies in his right scrub top pocket. Nurse #1 walked down the hall to Resident #36's room and took out the alcohol wipes, gloves, lancet, glucometer, insulin syringe, vial of Humalog, Levemir Flexpen and pen needle. Nurse #1 then placed the supplies on the dresser for Resident #36. Nurse #1 collected a blood sample to test the blood glucose from the resident's forefinger. He then squeezed the drop of blood onto blood glucose test strip. The glucometer read the blood glucose to be 282. Resident #36 asked what was his blood sugar and Nurse#1 stated, "I'm sorry I need to get another Levemir Flexpen since I do not have enough in the Flexpen I brought." Nurse #1 then gathered the used gloves, the clean gloves, used test strip with the blood drop, the used lancet, alcohol wipes, gloves, the dirty glucometer, insulin syringe, vial for Humalog, Levemir Flexpen, and pen needle inserted with a cap and put them in his scrub's top pocket. Nurse #1's right scrub top pocket was noted to have 1 ink	F 726	nurses will receive the skills validation on Glucose Monitor Cleaning/Disinfecting and Hand washing requirements during orientation and have return demonstration validated by the Director of Nursing or the Unit Manager before being released to work on the medication carts. " To ensure staff competency before performing independent resident care, any nurse unable to show competency after the orientation and training program will be retrained or employment ended as directed by the Director of Nurses The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements " Regional Nurse Consultant (or designee) will audit skills validation worksheets for completion once weekly beginning 5-24-18 for 4 weeks and then monthly x 5 months. " Beginning on 5-25-18, random audits will be conducted to ensure glucometer cleaning and hand washing are performed per facility policy. Audits will be done 5 times weekly x 2 weeks, 3 times weekly x 2 weeks, and then once weekly x 2 months. Audits will be performed by Director of Nursing, Unit managers, Regional Nurse Consultant or designee. The nurse consultant will review the audits with the Director of Nursing and the Administrator who will report findings to the QAPI committee. " The Administrator will validate that each licensed nurse has a skills validation	

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F 726	Continued From page 16 pen, the second nebulizer treatment for Resident #47, and all the above items for Resident #36. On 5/23/18 at 9:20am Nurse#1 was observed as he walked down the hall to room for Resident #47 and then reached into his right pocket to administer the second nebulizer treatment. He placed the nebulizer face mask on to Resident #47 and started the treatment using the second medication. An interview with Nurse #1 on 5/23/18 at 9:35am revealed there was no one to ask for help when needed. He stated he had received no job training before his first shift when he was assigned to a medication cart. Nurse #1 explained Nurse #4 who no longer worked at the facility, pulled the medications and he had administered the medications to the residents during his first shift in the facility. An interview on 5/23/18 at 3:27pm with the Administrator was conducted. The Administrator revealed Nurse#1 had received orientation training by the Staff Development Coordinator (SDC) and had received ongoing training on time management and consolidating methods to use during a medication pass. The Administrator was unable to provide any evidence of specific training given to Nurse #1. During observations on 5/23/18 between 4:48pm to 5:12pm of a medication pass with Nurse #2, Nurse #2 was observed not disinfecting a shared glucometer, changing her gloves but not washing	F 726	completed within 30-days of hire and annually and report findings to the QAPI committee. " The Administrator will confirm that each licensed nurse has received the skills validation on Glucose Monitor Cleaning/Disinfecting and Hand washing requirements during orientation and has been observed with return demonstration validated by the Director of Nursing or the Unit Manager before being released to work on the medication carts. The title of the person responsible for implementing the acceptable plan of correction Regional Nurse Consultant, Director of Nursing and Administrator with completion by 5-25-18.	

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her hands between glove changes for 5 residents (Resident #73, Resident #72, Resident #67, Resident #74, and Resident #223).

During an interview on 5/23/18 at 5:10pm, Nurse#2 was asked if she had been washing her hands in between removing gloves and placing new gloves on. Nurse #2 stated no, she had been so nervous that she had forgotten. She explained she knew how essential it was to wash her hands when taking off gloves to put on new gloves. She then sanitized her hands with the hand gel stored on top of her medication cart.

During an observation on 5/23/18 at 5:18pm, Nurse #2 was observed asking Nurse#3 how the shared glucometer was to be disinfected. Nurse #3 instructed Nurse #2 to disinfect the glucometer with an alcohol wipe for 2 minutes. Nurse #2 walked back to her cart, found alcohol wipes and wiped the used glucometer.

During an observation on 5/23/18 at 5:27pm, Nurse #2 walked to the office by the nurse's station on Hall 100 and asked the Director of Nursing (DON) and UM #1 how to disinfect a shared glucometer. Both the DON and UM#1 instructed Nurse #2 to use a sani wipe for 2 minutes and together walked back to the cart with Nurse #2 to assist.

During an observation on 5/23/18 at 5:27pm, UM#1 and the DON were observed educating Nurse #2 on how to disinfect the glucometer. The observed instructions given by the DON and UM

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F 726	Continued From page 18 #1 to Nurse #2 was to wipe the glucometer off for 2 minutes with a PDI (PDI Sani Cloth Bleach Germicidal Disposable Wipe) wipe, then air dry for 1 minute, then dry off any leftover chemical on the device and to follow the steps after every use of the shared glucometer. An interview on 5/23/18 at 5:35pm with Nurse#2 revealed she had never been told how to disinfect a glucometer and had not received formal orientation. Nurse #2 explained, since she had worked at the facility for the last 3 weeks, she had used alcohol wipes to disinfect the glucometer when it had been available. She explained she had just moved from another state and was taught to disinfect glucometers with alcohol there. An interview on 5/23/18 at 5:50pm was conducted with the Nurse Consultant who stated the contact time for the PDI wipe was 4 minutes. An interview on 5/23/18 at 6:13pm after observation of a medication pass with Nurse #3, revealed she had been in-serviced about 15 to 20 minutes ago and was told to use alcohol wipes for 4 minutes now instead of 2 minutes as before to disinfect the glucometers. She stated she had not received formal training and had only worked in the facility for 3 weeks. Nurse #3 indicated the only in-service she had received since working in the facility had been on falls. Nurse #3 explained she had received a Human Resources (HR) employee handbook but nothing about glucometers.	F 726		

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During an interview with the Administrator on 5/23/18 at 7:40pm she revealed Nurse #3 was a return employee to the facility from 1 year ago and had not received formal training. She indicated that Nurse #1, Nurse #2, and Nurse #3 had all received training and should have known how to disinfect the shared glucometers as part of their training.

An interview on 5/24/18 at 9:19am with the facility Medical Director was conducted via the telephone. He stated the breach in infection control due to absence of disinfection of the glucometers in his prospective was absolutely concerning. He explained the risk for cross-contamination was always there. The Medical Director further explained that we may not know if a resident had Hepatitis B or Hepatitis C and mandatory Universal precautions were to be used always. The Medical Director stated the need for training for all nurses including new hires was imperative. He explained the facility needed to set the standards from Day 1 regarding all nursing education including disinfecting glucometers. The Medical Director revealed the SDC (Staff Development Coordinator) who was responsible for educating the staff had left about 2 weeks previous and had given her notice 2 to 3 weeks before her last day. The last 5 to 6 weeks while the SDC worked in the facility, she was pulled to a medication cart due to nurse call-outs sometimes 15 to 20 minutes prior to a shift. At the same time nurses were let go by the facility for not meeting professional standards. It had been a bad time for staffing he explained. The Medical Director revealed the SDC had been physically in the building but could not train staff because she kept getting pulled to a cart. The

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Medical Director explained a germicidal must be used for a shared glucometer and the only time alcohol would be acceptable was if each resident had their own glucometer and were individually bagged and labeled.

An interview on 5/24/18 at 11:09am with the Corporate Nurse Consultant revealed the facility did not have any signed off education for Nurse #1, Nurse #2, and Nurse #3 for any specific training or orientation records.

On 5/24/18 at 12:20pm the Nurse Consultant provided orientation training acknowledgement related to bloodborne pathogens dated 4/18/18 and signed by Nurse #2 and the SDC. No documentation could be provided for the training of disinfecting a shared glucometer for Nurse #1, #2, or #3. No evidence of any training for Nurse #3 was provided.

An interview on 5/25/18 at 9:52am with the SDC was conducted via the telephone. The SDC revealed she was on vacation and had planned on returning to the facility in the role of a MDS Coordinator. She indicated glucometer disinfection was taught verbally during the Bloodborne Pathogen PowerPoint on the third day of orientation. Handwashing training was taught during the Bloodborne Pathogen PowerPoint presentation, during infection control, and multiple times during orientation. New hires were given written and verbal education but no return demonstrations were included in the training. The SDC revealed she personally had been on the floor with Nurse #1 and also rounded

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on him and had never seen Nurse #1 transport a used blood sample test strip in his pocket. The SDC stated she had expected for nurses to take a small sharps container into the room and they should absolutely not put a used test strip in their scrub pocket. She reiterated, "Nothing goes in the pocket, the strip goes directly into the sharps container." During the interview the SDC indicated Nurse #2 had received training on bloodborne pathogens but she could not remember who had trained Nurse #3 and believed there had been a scheduling conflict. She stated Nurse #3 did receive orientation to the best of her memory. The SDC stated she expected nurses to wash their hands before putting on new gloves, disinfect the glucometer, and then the nurse should use the second glucometer on the medication cart for the next resident until the 4 minute contact time for the PDI wipes had expired. The SDC explained the new hire nurses received a skills validation form and their preceptor checked the skills off once on the floor. She continued, once the skills validation form was completed the new nurse would bring the form back to the SDC and the SDC would review any competencies unsigned. She revealed new hires received mentors who were considered to be the preceptor on the floor. The SDC explained there were no records on who the new nurse was trained by and the nursing leadership team determined who precepted who based on the schedule and best fit between the nurses. The SDC revealed neither Nurse #2 nor Nurse #3 had been rounded by her because they were new to the facility.

An interview on 5/25/18 at 10:42am with the Nurse Consultant revealed Nurse #4 had been

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the mentor for Nurse #1, Nurse #5 had been the mentor for Nurse #2, and Nurse #6 had been the mentor for Nurse #3. (The SDC had explained the mentor was considered to be the preceptor for a new hire.)

During an interview on 5/25/18 at 11:07am, the Administrator revealed the Regional Manager had included UM #1 and the DON in the training on 5/23/18 related to correctly disinfecting the glucometers due to both giving incorrect directions to Nurse #2 on 5/23/18. The Administrator indicated she was aware of the facility training policy and explained the nurse turn-over in the facility had been high. She stated the facility needed a solid orientation to be successful. The administrator added that Nurse #2 and Nurse #3 should have been rounded (rounds by the leadership team to ensure nurses provided appropriate care) on by the UM #1.

An interview with Nurse #5 on 5/25/18 at 12:25pm revealed the facility did not have mentors in place and she had only trained Nurse#2 for one shift. Nurse #5 indicated Nurse #2 had not asked her how to disinfect a glucometer and the topic had not been discussed.

An interview on 5/25/18 at 12:32pm with UM #1 revealed she had worked in the facility for 2 months and attended orientation for Day 1 only. She indicated after Day 1 she followed the past DON for a few days reviewing the facility policies and daily checklist for managers. UM #1 revealed there had been no training related to disinfecting a glucometer. She added, overall the

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F 726	Continued From page 23 nursing staff needed better training. The Administrator and Corporate Nurse Consultant were informed of Immediate Jeopardy on 5/24/18 at 3:32pm. The Administrator provided an acceptable credible allegation of compliance on 5/25/18 at 4:32pm. On 5/25/18 at 3:52pm, record review revealed the specific Skills Competency Validation Record for nurses regarding resident care located in the facility assessment notebook had not been completed for Nurse #1, Nurse #2, and Nurse #3. Credible Allegation F726: The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. As part of the root cause analysis of the deficient practice by the administrator, a review and analysis of the facility orientation for licensed nursing staff was conducted; it was noted that there was not a specific skills validation for the competency of nursing staff in cleaning glucometers and hand washing signed as part of their blood borne pathogens training. When the staff development coordinator was questioned, she stated that she gave the forms to the staff and expected them to complete them with their training nurse and return them to her but did not validate their completion. The root cause analysis also revealed that the Director of Nursing was not evaluating	F 726		

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F 726	Continued From page 24 competency on newly hired nurses prior to a nurse being released to floor. Nurse #2 did not clean the glucometer after the accucheck on Resident #73 and proceeded to perform accuchecks on residents # 72, 74, 67, 223. Nurse #2 was also observed not sanitizing her hands between glove changes. Nurse #2 was immediately removed from patient care, and in-serviced. Nurse #2 did not return to patient care until a return demonstration was validated by an RN; any further demonstration of incompetent practices will result in immediate termination. Nurse #3 expressed lack of knowledge by instructing Nurse #2 to disinfect the glucometer by using the wrong cleaning supply by using alcohol wipes after the completion of an accucheck. Nurse #3 was in-serviced immediately and returned to patient care as soon as she verbalized correct cleaning procedures, return demonstration, and a quiz following the education to determine knowledge retention. During the analysis of the deficient practice of Nurses #2 & #3, the nurses expressed to the direct supervisor that they knew to clean the glucometers but also thought alcohol wipes were an appropriate alternative for cleaning. After receiving the first inservice education on 5/23/18, Nurse #3 was unable to verbalize the correct process when questioned by the surveyor. Nurse # 3 then received additional training with return demonstration conducted by the Regional Nurse Consultant on 5/23/18. Nurse #2 admitted that she knew she needed to disinfect the glucometers but did not. The procedure for implementing the acceptable plan of correction for the specific deficiency cited.	F 726		

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Facility nursing staff are being in-serviced beginning on 5/23/18 on the policy on Patient Care Equipment including: use of PDI Sani-Wipes, and wet time. Facility nursing staff are being in-serviced beginning on 5/23/18 on the policy Handwashing Requirements. Facility nursing staff also acknowledged by signature the understanding of transmission precautions and that proper hand washing and glucometer disinfecting was required to prevent the transmission of blood borne pathogens.
Education was provided by the Regional Nurse Consultant to the Director of Nursing and Unit Managers with return demonstration and then Education was provided by DON, Unit managers, and Regional Nurse Consultant to the facility licensed nursing staff. New hires will be educated during general orientation by a member of nursing administration. All nursing staff will be in-serviced before returning to work.
Facility medication carts were provided with a job aide describing the steps to cleaning a glucometer as a visual reference for the staff on the competent technique to use on 5/23/18 by the Regional Nurse Consultant.
Beginning 5/24/18, current nurses will have skills validation sheets completed on Glucose Monitor Cleaning/Disinfecting and Blood Borne Pathogens. All new nurses will receive the skills validation on Glucose Monitor Cleaning/Disinfecting and Hand washing requirements during orientation and have return demonstration validated by the Director of Nursing or the Unit Manager before being released to work on the medication carts.
To ensure staff competency before performing independent resident care, any nurse unable to show competency after the orientation and training program will be retrained or employment

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F 726	Continued From page 26 ended as directed by the Director of Nurses The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. Regional Nurse Consultant (or designee) will audit skills validation worksheets for completion once weekly beginning 5/24/18 for 4 weeks and then monthly x 5 months. Beginning on 5/25/18, random audits will be conducted to ensure glucometer cleaning and hand washing are performed per facility policy. Audits will be done 5 times weekly x 2 weeks, 3 times weekly x 2 weeks, and then once weekly x 2 months. Audits will be performed by Director of Nursing, Unit managers, Regional Nurse Consultant or designee. The nurse consultant will review the audits with the Director of Nursing and the Administrator who will report findings to the QAPI committee. The Administrator will validate that each licensed nurse has a skills validation completed within 30-days of hire and annually and report findings to the QAPI committee. The Administrator will confirm that each licensed nurse has received the skills validation on Glucose Monitor Cleaning/Disinfecting and Hand washing requirements during orientation and has been observed with return demonstration validated by the Director of Nursing or the Unit Manager before being released to work on the medication carts. The title of the person responsible for implementing the acceptable plan of correction: Regional Nurse Consultant, Director of Nursing and Administrator with completion by 5/25/18.	F 726		

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F 726	Continued From page 27 Immediate Jeopardy was removed on 5/25/18 at 6:34pm when observations, interviews, and review of the in-services provided on 5/23/18 revealed nurses were knowledgeable about disinfecting glucometers and transporting used blood glucose test strips safely to a sharps container. Nurses demonstrated how to obtain blood glucose readings and disinfecting glucometers after each use as recommended by the manufacturer's instructions on the wipes provided by the facility.	F 726		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		6/25/18

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F 761	Continued From page 28 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, record review and staff interviews, the facility failed to remove expired medications from 3 of 4 medication carts. In addition, the facility failed to lock an unattended medication cart for 1 of 4 medication carts observed (Hall 200,cart #2). The findings included: Review of the facility's medication storage policy titled "8.2 Disposal/Destruction of expired or discontinued medications" revised June 30, 2016 read in part, the facility should place all discontinued or outdated medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction. 1a. An observation of the 100 Hall medication cart was conducted on 5/23/18 at 2:41 PM with Nurse #7. The observation revealed an opened sleeve of Tramadol 50 milligrams (mg) that expired 3/31/18 and an unopened sleeve of Lorazepam 1mg that expired 4/30/18, both were in the locked narcotic box on the cart available for use. An interview was conducted with Nurse #7 on 5/23/18 at 2:45 PM. Nurse #7 stated she was	F 761	The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. The facility failed to remove expired medications from the carts and either dispose of or return to pharmacy; the facility also had one nurse who failed to lock his medication cart during the medication pass. The nurse who left the medication cart unlocked is no longer employed by the facility. The expired medications and unlabeled medications were immediately discarded. The expired narcotics were secured in the cart until return and were not for patient use; they were processed and returned to pharmacy. Nursing staff were directed to refer to the pharmacy tip sheets on medication storage/labeling, product destructions, and product returns. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. The Director of Nursing provided facility licensed nurses education on the labeling and storage of drugs and the pharmacy tip sheets by 6-22-18. Nursing administration verified that each medication cart was provided with the pharmacy tip sheets for the nursing staff to reference as needed. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected	

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F 761	Continued From page 29 unsure what to do with the expired medication. She added she thought they needed to be put in a clear bag and a special form needed to be completed, and a call to transport to pick it up. She further stated that some couriers do not take narcotics so she kept them locked in her cart. b. An observation of the 200 Hall medication cart was conducted on 5/23/18 at 3:53 PM with Nurse #9. The observation revealed an opened bottle of Aspirin 81mg that expired 1/2017 that was available for use. An interview was conducted with Nurse #9 on 5/23/18 at 3:55 PM. Nurse #9 stated that all nursing staff who administered medication are responsible for disposing expired medications. An interview was conducted on 5/23/18 at 5:00 PM with interim Director of Nursing (DON). The DON stated she expected the nurses to follow the policy and remove all expired medications. She further stated she expected the nurses to put all expired narcotics in a sealed clear bag with the designated number on it, fill out the form and fax to pharmacy. She stated pharmacy will pick up all medications listed on that completed faxed form. Those bags are to be properly secured in a double locked room in the 200 Hall medication room. An interview was conducted on 5/25/18 at 11:47 AM with the facility Administrator. The Administrator stated she expected the staff to follow the pharmacy policy for disposal and	F 761	and/or in compliance with the regulatory requirements. Nursing administration will conduct medication pass audits monthly x 3 months and then quarterly to monitor for proper labeling and storage of drugs on the medication cart. The facility pharmacist will also review medication carts monthly and report any concerns with labeling and storage of drugs to the Administrator and the Director of Nursing. The results of the mediation pass audits and the pharmacy reviews will be reported to the QAPI committee for analysis of any patterns, trends, or need for further systemic changes. Any staff found to be non-compliant with the storage and labeling of drugs will receive progressive discipline. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the acceptable plan of correction by 6-25-18.	

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destruction of expired or discontinued medications.

2. An observation was made of a medication pass on Hall 200, medication cart #2 with Nurse #1 on 5/23/18 at 9:31am. Nurse #1 was observed to prepare medications for administration and after dispensing two different nebulizer treatments he walked away from his medication cart to Resident #47's room. The medication cart was observed unlocked and not visible to Nurse #1. Staff members and a resident ambulating independently via a wheelchair were observed to pass the cart.

An interview was conducted with Nurse #1 at 9:35am. Nurse #1 confirmed he had left the medication unlocked while administering a nebulizer treatment in Resident #47's room. He stated he just forgot because he was so busy and had a heavy assignment.

An interview with the Corporate Nurse Consultant on 5/23/18 at 3:18pm indicated it was the facility's expectation to keep the medication carts locked while unattended by the assigned nurse.

An interview with the Administrator on 5/23/18 at 3:27pm revealed she expected the medication cart to have been locked after Nurse #1 prepared medication and left the cart to administer to the resident.

3. An observation was made on Hall 200,

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F 761	Continued From page 31 medication cart #2 with Nurse #1 on 5/23/18 at 9:01am. A Humalog (insulin) vial was observed open with no opened date written on the label. Nurse #1 picked up another Humalog vial in his cart and the vial was expired with an open date labeled 4/20/18. An interview on 5/23/18 at 9:01am with Nurse #1 revealed different nurses had work his cart and the label that was not dated on the insulin vial must had gotten torn off to order new insulin from the pharmacy. Nurse #1 stated the expired insulin must have been an oversight. An observation on 5/23/18 at 9:01am revealed Nurse #1 discarded the undated and expired insulins in his sharps container. Nurse #1 was observed getting a new vial from the medication room on Hall 200 and labeled the vial with an open date and initialed his name. The sticker on the Humalog insulin read to discard after 28 days from the open date. An interview on 5/23/18 at 3:18pm with the Nurse Consultant and Administrator was conducted. The expectations of the facility were indicated as once an insulin vial had been open for use, the vial should have been dated. Vials expired after the open date per the pharmacy guidelines, should be discarded.	F 761		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must-	F 803		6/25/18

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F 803	Continued From page 32 §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and review of menus the facility failed to serve a 4 ounce portion of macaroni and cheese, pureed macaroni and cheese, pureed pinto beans, and minced meats as per the menu for 4 of 11 foods available on lunch meal tray line. The findings included: On 05/21/18 from 11:36 AM - 12:34 PM the Certified Dietary Manager (CDM) was observed	F 803	The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. On 5-21-18, the cook used a 2-ounce scoop to serve the puree and the minced and moist portions instead of a 4-ounce scoop. The Dining Services Manager replaced the 2-ounce scoop with a 4-ounce scoop on the tray line. He also educated the cook on the importance of checking the diet guide prior to setting up the tray line to ensure that we are serving the correct portion sizes. The Corporate	

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F 803	Continued From page 33 preparing foods for that days lunch meal and placed all foods and serving utensils on the steam table. The CDM was observed to place a 2 ounce (#16 scoop) serving utensil on the steam table for the macaroni and cheese, pureed foods and minced meats. Interview with the CDM during the observation revealed he was preparing foods for 70 residents on a regular diet, 8 residents on a pureed diet and 3 residents on a minced foods diet. Review of the 05/21/18 lunch meal menu revealed the following foods were to be served in 4 ounce portion: macaroni and cheese pureed macaroni and cheese pureed pinto beans minced pork chop On 05/21/18 from 12:30 PM to 1:20 PM, dietary staff #1 (DS #1) was observed to plate foods for the lunch meal tray line service. He served a 2 ounce portion of macaroni and cheese, pureed macaroni and cheese, pureed pinto beans and minced pork chop to residents on a regular, pureed and minced foods diet. During an interview on 05/21/18 at 1:20 PM, DS #1 stated that the lunch tray line was set up when he arrived, he did not place the serving utensils on the tray line, and he did not verify the portions of foods before starting the tray line. He stated that he did not usually serve foods for the lunch meal and that he was filling in. An interview on 05/21/18 at 1:22 PM with the	F 803	Dietitian and Dining Services Manager reviewed scoop sizes and the importance of serving the correct portion sizes with dining services staff working during the morning of 5-22-18. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. Dining services staff received in-service education on scoop sizes and portion sizes; completed by 6-22-18. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The Dining Services Manager will audit to ensure that scoop sizes are used according to the diet guide weekly x 4 weeks, then monthly x 2 months, then quarterly x 1 quarter to ensure deficient practice does not recur. The Corporate Dietitian will also monitor scoop sizes on the tray line during her weekly facility visits and include this on her weekly visit report to Administration. The results of the audits will be reported to the QAPI committee for analysis of any patterns, trends, or need for further systemic changes. Any staff found to be non-compliant will receive progressive discipline. The title of the person responsible for implementing the acceptable plan of correction. Dining Services Manager is responsible	

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F 803	Continued From page 34 CDM reveaeld he set up the foods and serving utensils for the lunch meal tray line service that day. The CDM stated that he usually served 2 scoops of the foods to provide a 4 ounce portion, but that he did not provide that instruction to DS #1. An interview occurred on 05/21/18 at 1:30 PM with the consultant registered dietitian (RD). During the interview the RD reviewed the menu and stated that a 4 ounce portion of macaroni and cheese, pureed macaroni and cheese, pureed pinto beans and minced pork chop should have been served. The RD further stated that she expected the cook to monitor the portions served, but since the CDM filled in as the cook that day, the CDM should have provided the oversight. The Administrator was interviewed on 05/25/18 at 11:38 AM and stated that she had already been made aware of the incorrect portions of foods served during lunch on 5/21/18. The Administrator stated that she expected the dietary staff to follow the menu for portions and the CDM to oversee this.	F 803	for implementing the acceptable plan of correction by 6-25-18.	
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat	F 806		6/25/18

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F 806	Continued From page 35 food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, family and staff interviews and medical record review, the facility failed to provide regular scrambled eggs to honor a resident's choice for 1 of 7 sampled residents reviewed for food preferences (Resident #6). The findings included: Resident #6 was admitted to the facility on 7/30/12. Diagnoses included Alzheimer's disease, protein calorie malnutrition, hypertensive chronic kidney disease stage 4, and right hand contracture, among others. A 2/10/18 annual minimum data set (MDS) assessed Resident #6 as having no speech, rarely/never understood, rarely/never understands, severely impaired cognition, and required extensive staff assistance with eating. The MDS also assessed Resident #6 required a mechanically altered, therapeutic diet. A 2/10/18 Care Area Asssessment (CAA) and nutrition care plan documented that Resident #6 had varied food intake of 0-75% of meals fed to her by staff. The CAA and care plan also documented that Resident #6 was underweight and due to the Resident's risk for a decline in nutrition status, poor food intake, therapeutic diet, advanced age and need for supplements, staff would honor her food preferences to help	F 806	The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. On 5-24-18, resident #6 received pureed scrambled eggs instead of regular scrambled eggs, as requested on her tray ticket. The Dining Services Manager immediately brought the resident a bowl of regular scrambled eggs. The Corporate Dietitian and Dining Services Manager immediately educated the staff on duty in the importance of honoring resident□s food preferences and sending every food item as requested on resident□s tray tickets. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. The corporate dietician provided facility dining services staff with an in-service on resident□s food preferences and tray accuracy; completed by 6-22-18. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The Dining Services Manager will complete a tray accuracy audit weekly x 4 weeks, then monthly x 2 months, then quarterly x 1 quarter to ensure deficient practice does not recur. The Corporate Dietitian will also conduct quarterly tray accuracy audits and include this on her weekly visit report to Administration. The	

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F 806	Continued From page 36 maintain a stable weight. A 3/28/18 physician's order recorded Resident #6 received a regular pureed texture diet. Resident #6 was observed in her room on 05/22/18 at 09:26 AM fed by restorative aide #1 (RA #1). RA #1 stated that she fed Resident #6 breakfast every morning because she required assistance and more time to eat. Resident #6 was observed to be fed a pureed diet of eggs, oatmeal, waffle, and juice. RA #1 stated that Resident #6 did not like the pureed eggs and did not eat them well, but liked/ate her oatmeal. RA #1 further stated that Resident #6 received the pureed eggs most mornings, but usually did not eat them. The tray card on her breakfast meal tray recorded "Regular - Pureed, Send regular scrambled eggs." Resident #6 received pureed eggs instead of regular eggs. Resident #6 was offered the pureed eggs, took a small bite, but refused to open her mouth for more pureed eggs. Resident #6 was observed in the main dining room on 05/23/18 at 1:15 PM fed lunch by a family member. The family member stated that Resident #6 ate scrambled eggs, bacon and toast every day for breakfast for years. The family member stated that Resident #6 would not eat the pureed eggs and the family requested that she receive regular textured scrambled eggs. The family member stated, "They (eggs) are soft enough for her and we would like for her to get that instead of the pureed eggs, which she will not eat."	F 806	results of the audits will be reported to the QAPI committee for analysis of any patterns, trends, or need for further systemic changes. Any staff found to be non-compliant will receive progressive discipline. The title of the person responsible for implementing the acceptable plan of correction. Dining Services Manager is responsible for implementing the acceptable plan of correction by 6-25-18.	

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Resident #6 was observed in her room on 05/24/18 at 8:20 AM fed breakfast by RA #1. Resident #6 received milk, cranberry juice and a pureed texture breakfast of sausage, oatmeal and eggs. The tray card on her breakfast tray recorded "Regular - Pureed, Send regular scrambled eggs." Resident #6 received pureed eggs instead of regular eggs. RA #1 stated "Everything she gets is pureed. I don't really look at the bottom of the tray card. I feed her most mornings and did not notice the tray card said she should get the regular scrambled eggs."

The Certified Dietary Manager (CDM) observed Resident #6 with her breakfast meal on 5/24/18 at 8:30 AM as requested by the surveyor. The CDM reviewed the tray card, confirmed the Resident received pureed eggs and stated that Resident #6 should have received regular texture scrambled eggs as per the family request and as per the tray card.

During an interview on 5/24/18 at 8:35 AM, the interim Director of Nursing (DON) stated she would expect staff who assisted residents with their meal to review the tray card and ensure all items listed on the tray card were available to the resident so that the resident's preferences were honored. The interim DON further stated that if a food item was missing, she expected staff to go to the kitchen to obtain the missing item, but that she also expected dietary staff to send all food items to the resident as per the tray card.

During an interview with the registered dietitian

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F 806	Continued From page 38 (RD) on 5/24/18 at 9:30 AM, she stated that the family request for Resident #6 to receive regular scrambled eggs had been in the tray card system since 2016 and she expected preferences to be honored. The RD further stated that when a requested food item was not in line with the physician's order, the facility honored the request and educated the resident/family on the consequences of their decision. A follow up interview with RA #1 occurred on 5/24/18 at 9:45 AM and revealed Resident #6 later received the regular scrambled eggs and ate 50% of the regular scrambled eggs compared to the 0-25% she usually ate of the pureed eggs.	F 806		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		6/25/18

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F 812	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to use beard guards for 2 of 2 male staff involved in food preparation. Additionally, the facility failed to monitor produce (kale and bell peppers) for signs of spoilage, store ice cream 0 degrees Fahrenheit or below for 2 of 3 cold storage units observed and store clean dishes to air dry. The findings included: A continuous observation of the dietary department occurrred on 05/21/18 from 11:36 AM - 1:20 PM. The following problems were observed: A. On 5/21/18 from 11:36 AM - 12:34 PM, the certified dietary manager (CDM) prepared foods for the lunch meal tray line while wearing a beard guard that did not cover his mustache or all of the facial hair to his cheeks/chin. The CDM stated on 5/21/18 at 12:31 PM that he was not aware that beard guards should cover all facial hair and that he did not take into account his mustache. B. On 5/21/18 from 12:15 PM - 1:20 PM, Dietary staff #1 prepared and plated foods for the lunch meal tray line service while wearing a beard guard that did not cover his mustache or all of the	F 812	The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. • Dining staff was noted not having the beard guard covering their mustache as well as their full beard during the meal service. On 5-25-18, the Dining Services Manager and staff were educated on the appropriate use of beard guards to include covering of the cheeks, chin, and mustache by the Corporate Dietician. • On 5-21-18, expired food items were identified (an unopened bag of fresh kale and a moldy bell pepper) and discarded immediately by the Corporate Dietitian. • Ice cream was stored in an insulated freezer bin in the reach-in refrigerator prior to meal service to soften them for resident consumption. The Corporate Dietitian discarded the ice cream immediately. • Stainless steel braising pans and stainless steel bowls were stacked together on two drying racks and had water droplets. The Corporate Dietitian separated the pans and bowls to allow them to air dry completely. • The Corporate Dietitian and Dining Services Manager reviewed proper food storage procedures and the importance of air-drying all pots/pans with all dining services staff working during the morning of 5-21-18. The Dining Services Manager reviewed the appropriate use of hair restraints (hairnets, hair coverings, and beard guards) with all staff working during the morning of 5-25-18.	

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F 812	Continued From page 40 facial hair to his cheeks/chin. On 5/24/18 at 2:25 PM, Dietary Staff #1 stated he cooked most days and his typical practice was to cover his beard, but not his mustache. He stated he had not been trained to cover his mustache. C. On 5/21/18 from 11:48 AM - 11:55 AM, The walkin-in refrigerator was observed with the following problems: A box of 10 bell peppers was observed, 2 of which had black/white fuzzy hair-like growth in various spots on the bell peppers. The bell peppers were discarded. A 5 pound bulging bag of kale was observed with brown, mushy pieces in a brown pooling liquid with a manufacturer "Best by Date" of 4/17/18. The kale was discarded. The CDM stated on 5/21/18 at 11:48 AM that he usually monitored refrigeration units daily, but did not check them over the weekend. E. On 5/21/18 at 12:04 PM, the reach-in refrigerator was observed at 40 degrees Fahrenheit with 6 cups of vanilla ice cream stored that were soft to touch, not frozen. The ice cream was discarded. The CDM stated on 5/25/18 at 12:31 PM that the ice cream should have been stored in the freezer. F. On 5/21/18 at 12:00 PM, two pot/pan storage racks were observed with stainless steel bowls	F 812	The procedure for implementing the acceptable plan of correction for the specific deficiency cited. Dining services staff were in-serviced by the Dining Services Manager and the Corporate Dietician on proper food storage practices, appropriate use of hair restraints (hair nets, hair coverings, and beard guards), and the importance of air drying all pots/pans; completed by 6-22-18. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The Corporate Dietitian will monitor for sanitation to meet regulatory standards during her weekly facility visits and include this on her weekly visit report to Administration. The Dining Services Manager will audit appropriate use of hair restraints weekly x 4 weeks, then monthly x 2 months, then quarterly x 1 quarter to ensure deficient practice does not recur. The Dining Services Manager will audit food storage in all refrigerators and freezer weekly x 4 weeks, then monthly x 2 months, then quarterly x 1 quarter to ensure deficient practice does not recur. The Dining Services Manager will audit drying procedures to ensure that all pots and pans are air dried appropriately	

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F 812	Continued From page 41 and stainless steel pans stored wet and stacked one on top of the other. The Registered Dietitian stated on 5/21/18 at 12:00 PM that dishes were supposed to be inverted or placed in a single layer/row to air dry. The CDM stated on 5/25/18 at 12:31 PM that the storage racks were set to have everything positioned so that all items were stored slanted to drain, once pot/pans were dry, then the items could be stacked. During an interview on 5/25/18 at 11:38 AM, the Administrator stated she expected the CDM to manage the kitchen to Serve Safe standards.	F 812	weekly x 4 weeks, then monthly x 2 months, then quarterly x 1 quarter to ensure deficient practice does not recur. The results of the audits and the will be reported to the QAPI committee for analysis of any patterns, trends, or need for further systemic changes. Any staff found to be non-compliant will receive progressive discipline. The title of the person responsible for implementing the acceptable plan of correction. Dining Services Manager is responsible for implementing the acceptable plan of correction by 6-25-18.	
F 835 SS=K	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, physician, and staff interviews the administration failed to provide oversight and leadership to facility nurses to ensure policies and training related to infection control practices were reviewed and updated to guarantee the current standards of practice were followed for disinfecting multi-use blood glucometers, safe handwashing practices,	F 835	The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. " The facility will continue the plan of correction initiated on 5-23-18. " During the analysis of the deficient practice of Nurse #1, the nurse admitted to not following proper procedure by	6/25/18

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F 835	Continued From page 42 transporting used blood glucose test strips safely to a sharps container, and preventing transmission of bloodborne pathogens. The failed practice was observed with 6 of 30 residents who had physician ordered blood glucose monitoring and had the potential to expose the residents to the risk for cross-contamination of bloodborne pathogens (Resident #47, Resident #73, Resident #72, Resident #67, Resident # 74, and Resident #223). Immediate Jeopardy began on 5/23/18 when Nurse #1 was observed during a medication pass to transport a blood sample test strip used on Resident #36 during blood glucose monitoring in his right scrub top pocket commingled with clean and dirty supplies that included a nebulizer treatment that would be later administered to Resident #47. On a separate medication pass observation Nurse #2 was observed not disinfecting a shared glucometer while collecting blood samples for blood glucose readings from 5 residents (Resident 73, Resident #72, Resident #67, Resident #74, and Resident #223). The Immediate Jeopardy was removed on 5/25/18 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (pattern with no actual harm with potential of more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to disinfecting glucometers, transporting supplies exposed to blood, and preventing transmission of bloodborne pathogens.	F 835	placing the glucometer strip for Resident #36 in his scrub pocket comingled with supplies for Resident #47 instead of placing the strip safely into the sharps container. " Nurse #1 was pulled off the cart immediately to discuss the deficient practice for infection control and possible cross contamination. Nurse #1 was then sent home and no longer is an employee of the facility. " No other nurses were identified as placing supplies with potential blood borne pathogens comingled into scrub pockets. " On May 23, 2018 during the evening shift, before dinner, Nurse #2 failed to display the proper technique for the cleaning and disinfecting of the glucometer between patient uses. Nurse #2 did not clean the glucometer after the accucheck on Resident #73 and proceeded to perform accuchecks on residents # 72, 74, 67, and 223 without cleaning or disinfecting the glucometer. Nurse #2 was immediately removed from patient care and in-serviced on the proper method for cleaning glucometers by the regional nurse consultant. She was also given a copy of the glucometer cleaning policy and procedure as well as the hand washing policy, as soon as the deficient practice was identified. Nurse #2 was then validated by return demonstration of the appropriate steps, following manufacturer guidelines for the cleaning of the glucometer, observed by the regional nurse consultant before returning to patient care. Nurse #2 is no longer employed by the facility and was reported	

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F 835	Continued From page 43 The findings included: 1.Cross Refer to F880 Based on record review, observations, physician, and staff interviews the facility failed to transport a used blood glucose test strip safely by placing the test strip in a scrub top pocket containing clean and dirty supplies for 2 of 2 residents (Resident #47 and Resident #36). In addition, the facility failed to follow safe practices for disinfecting a shared glucometer and performing handwashing during a medication pass for 5 of 5 residents (Resident # 73, Resident #72, Resident #67, Resident #74, and Resident #223). The failed practices had the potential to affect 6 of 30 residents who had physician ordered blood glucose monitoring in the facility at the time of the annual recertification by exposing the residents to the risk for cross-contamination of potential bloodborne pathogens (Resident #47, Resident 73, Resident #72, Resident #67, Resident #74, and Resident #223). 2.Cross Refer to F726 Based on observation, record review, physician, and staff interviews the facility failed to provide training to 3 of 4 facility nurses (Nurse #2, and Nurse #3) on how to disinfect a glucometer (a device used to test glucose level in the blood) that was shared among 5 residents and on how to dispose of a used sample test strip (Nurse #1) to avoid cross contamination of the residents' environment and to prevent disease transmission. The failed practice had the potential to affect 6 of 30 residents who had physician ordered blood glucose monitoring in the facility by exposing the residents to the risk for cross-contamination of potential bloodborne pathogens (Resident #47,	F 835	to the board of nursing. " Nurse #3 was asked by Nurse #2 which wipes were to be used to clean the glucometer and incorrectly stated it was cleaned with an alcohol wipe. Nurse #3 was in-serviced immediately by the regional nurse consultant and returned to patient care as soon as she verbalized correct cleaning procedures, return demonstration, and a quiz following the education to determine knowledge retention of the appropriate cleaning agent to use per manufacturer guidelines. " During the analysis of the deficient practice of Nurse #2, the nurse denied being trained on the cleaning of glucometers despite being presented with her signed acknowledgement of blood borne pathogens training on 4-18-18. The nurse expressed to her direct supervisor that she knew to clean the glucometers but thought alcohol wipes were the appropriate product for cleaning. The nurse also stated she was rushing because the surveyor watching her made her feel anxious and stressed. Upon review of the nurse□s medication cart, the appropriate supplies were available; there were two glucometers and the Sani-Wipes in a box in the bottom drawer of the cart for the disinfection of the glucometers. Further analysis confirmed that sufficient staff and supplies were available to perform the procedure per policy. " The cause of the nurses□ inability to perform was that they were unable to recall their training on cleaning of glucometers.	

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F 835	Continued From page 44 Resident 73, Resident #72, Resident #67, Resident #74, and Resident #223). A review of the facility assessment dated 11/2017 included a facility profile report that indicated 14% of current residents had infections and 32.6% received injections during 9/2016 through 9/2017. During an interview on 5/25/18 at 11:07am revealed the Administrator indicated she was aware of the facility training policy and explained the nurse turn-over and retention in the facility had been high. She stated the facility needed a solid orientation to be successful. She explained the past DON who had been responsible for the oversight had not been able to execute expectations and had been terminated due to the inability to retain nursing staff and stay organized. On 5/24/18 at 3:32pm, the Administrator and Nurse Consultant were informed of the Immediate Jeopardy for F835. On 5/25/18 at 3:52pm, record review revealed the specific Skills Competency Validation Record for nurses regarding resident care located in the facility assessment notebook had not been completed for Nurse #1, Nurse #2, and Nurse #3. On 5/25/18 at 4:32pm, the facility provided the following Credible Allegation of Immediate Jeopardy removal.	F 835	The procedure for implementing the acceptable plan of correction for the specific deficiency cited. " Beginning 5-24-18, the Director of Nursing and Unit Managers will be in-serviced on nurse education and competency skill validations, including the cleaning and disinfecting of glucometers) by Regional Nurse Consultant. " Staff also received training on blood borne pathogens as part of the skills validation, completed 6-22-18. " On 5-25-18, Director of Nursing and Unit Managers was in-serviced on performing a medication pass audit and observing accuchecks for proper technique by the Regional Nurse Consultant. " Facility nursing staff are being in-serviced beginning on 5-24-18 using a skills competency validation worksheet and return demonstration to ensure understanding of the training provided for glucometer cleaning and disinfecting. Facility nurses will not be able care for residents until they have received the skills competency validation on glucometer cleaning. " New nurses hired will be given a skills competency validation worksheet that must be completed within 30 days of hire, training on blood borne pathogens, and all new hires will be observed performing accuchecks and disinfecting the glucometer with the supplies and process recommended by the glucometer manufacturer. The nurse□s skills in the areas of blood borne pathogens	

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F 835	Continued From page 45 The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. On May 23, 2018 during the evening shift, before dinner, Nurse #2 failed to display the proper technique for the cleaning and disinfecting of the glucometer between patient uses. Nurse #2 did not clean the glucometer after the accucheck on Resident #73 and proceeded to perform accuchecks on residents # 72, 74, 67, and 223 without cleaning or disinfecting the glucometer. Nurse #2 was immediately removed from patient care and in-serviced on the proper method for cleaning glucometers by the regional nurse consultant. She was also given a copy of the glucometer cleaning policy and procedure as well as the hand washing policy, as soon as the deficient practice was identified. Nurse #2 was then validated by return demonstration of the appropriate steps, following manufacturer guidelines for the cleaning of the glucometer, observed by the regional nurse consultant before returning to patient care. Any further demonstration of incompetent practices by nurse #2 will result in immediate termination. Nurse #3 was asked by Nurse #2 which wipes were to be used to clean the glucometer and incorrectly stated it was cleaned with an alcohol wipe. Nurse #3 was in-serviced immediately by the regional nurse consultant and returned to patient care as soon as she verbalized correct cleaning procedures, return demonstration, and a quiz following the education to determine knowledge retention of the appropriate cleaning agent to use per manufacturer guidelines. During the analysis of the deficient practice of Nurse #2, the nurse denied being trained on the cleaning of glucometers despite being presented	F 835	understanding and glucometer cleaning and disinfection will be validated by nursing administration before the nurse can be released from orientation to do a medication pass independently. " Nursing staff will continue to have med-pass observations performed by the nursing administration team monthly x 3 months and then quarterly to ease their comfort to enable them to be less anxious and stressed while being observed during their observation by a surveyor. " The facility administrator in conjunction with the Regional Nurse Consultant will monitor the infection control program in the facility including effective leadership by nursing administration. The facility administrator will review the facility policies, procedures, manufacture instructions, and QAPI analysis of the infection control process in the facility with the QIO; completed 6-13-18. " The facility will not tolerate breaches of the infection control polices and expectations; staff will be disciplined using the progressive discipline process. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. " Regional Nurse Consultant (or designee) will audit skills validation worksheets including glucometer cleaning, for completion once weekly beginning 5-24-18 for 4 weeks and then monthly x 5 months.	

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F 835	Continued From page 46 with her signed acknowledgement of blood borne pathogens training on 4/18/18. The nurse expressed to her direct supervisor that she knew to clean the glucometers but thought alcohol wipes were the appropriate product for cleaning. The nurse also stated was rushing because the surveyor watching her made her feel anxious and stressed. Upon review of the nurse's medication cart, the appropriate supplies were available; there were two glucometers and the Sani-Wipes in a box in the bottom drawer of the cart for the disinfection of the glucometers. Further analysis confirmed that sufficient staff and supplies were available to perform the procedure per policy. The cause of the nurses' inability to perform was that they were unable to recall their training on cleaning of glucometers. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. Beginning 5/24/18, the Director of Nursing and Unit Managers will be in-serviced on nurse education and competency skill validations, including the cleaning and disinfecting of glucometers) by Regional Nurse Consultant. On 5/25/18, Director of Nursing and Unit Managers was in-serviced on performing a medication pass audit and observing accuchecks for proper technique by the Regional Nurse Consultant. Facility nursing staff are being in-serviced beginning on 5/24/18 using a skills competency validation worksheet and return demonstration to ensure understanding of the training provided for glucometer cleaning and disinfecting. Facility nurses will not be able care for residents until they have received the skills competency validation.	F 835	" Administrator (or designee) will review medication pass observation worksheets for completion monthly x12 months during the monthly QAPI meeting. " Facility pharmacy nurse consultant will monitor a sample of medication carts during his monthly visits for supplies and glucometer cleaning techniques. " The medical director will review the monitoring for trends and patterns during the quarterly QAPI meetings. " The director of nursing reported Nurse #2 to the board of nursing on 5-25-18; Nurse # 2 is no longer employed by the facility. The title of the person responsible for implementing the acceptable plan of correction. Director of Nursing, Regional Nurse Consultant, Pharmacist, and Administrator with completion by 5-25-18.	

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F 835	Continued From page 47	F 835		

New nurses hired will be given a skills competency validation worksheet that must be completed within 30 days of hire, training on blood borne pathogens, and all new hires will be observed performing accuchecks and disinfecting the glucometer with the supplies and process recommended by the glucometer manufacturer. The nurse's skills in the areas of blood borne pathogens understanding and glucometer cleaning and disinfection will be validated by nursing administration before the nurse can be released from orientation to do a medication pass independently.
Nursing staff will continue to have med-pass observations performed by the nursing administration team monthly x 3 months and then quarterly to ease their comfort to enable them to be less anxious and stressed an in being observed during their observation by a surveyor.
The facility administrator in conjunction with the Regional Nurse Consultant will monitor the infection control program in the facility including effective leadership by nursing administration.
The facility administrator will review the facility policies, procedures, manufacture instructions, and QAPI analysis of the infection control process in the facility with the QIO.
The facility will not tolerate breaches of the infection control polices and expectations; staff will be disciplined using the progressive discipline process.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.

Regional Nurse Consultant (or designee) will audit skills validation worksheets including

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F 835	Continued From page 48 glucometer cleaning, for completion once weekly beginning 5/24/18 for 4 weeks and then monthly x 5 months. Administrator (or designee) will review medication pass observation worksheets for completion monthly x12 months during the monthly QAPI meeting. Facility pharmacy nurse consultant will monitor a sample of medication carts during his monthly visits for supplies and glucometer cleaning techniques. The medical director will review the monitoring for trends and patterns during the quarterly QAPI meetings. The director of nursing reported Nurse #2 to the board of nursing on 5/25/18. The title of the person responsible for implementing the acceptable plan of correction: Director of Nursing, Regional Nurse Consultant, Pharmacist, and Administrator with completion by 5/25/18. Immediate Jeopardy was removed on 5/25/18 at 6:34pm when observations and interviews revealed nurses were knowledgeable about disinfecting glucometers, handwashing safe practices, and transporting used blood glucose test strips safely to a sharps container. Nurses demonstrated how to obtain blood glucose readings and disinfecting glucometers after each use as recommended by the manufacturer's instructions on the wipes provided by the facility.	F 835		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance.	F 867		6/25/18

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F 867	Continued From page 49 §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in June 2017. This was for three recited deficiencies which were originally cited in June 2017 during a recertification survey and were subsequently recited in May 2018 on an annual recertification survey. The deficiencies were in the areas of drug records, label/ storage and biologicals, increase/ prevent decrease in range of motion/ mobility, and food Procurement, store/ prepare/ serve- sanitation. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: F761 Label/ store Drugs and Biologicals: Based on observations, record review and staff interviews, the facility failed to remove expired medications from 3 of 4 medication carts. An interview with the Administrator and Regional	F 867	The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. " The facility failed to ensure expired medications were removed from the cart, the facility had previously been deficient in securing a storage room with nursing supplies. The facility performance improvement plan to ensure secure storage of medications was successful and not a repeated issue; the medications were secure but not removed from the cart during the survey. " The facility failed to apply an orthotic for one resident, the facility had previously been deficient in restorative programming. The facility had identified the restorative concern and the QAPI committee had already initiated a performance improvement plan prior to survey. " The facility failed to ensure food storage and use of beard guards met the guidelines. The facility QAPI committee has been working on these dietary areas and has seen improvement in the health inspection sanitation scores. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. The Administrator met with the Quality Improvement Organization on 6-13-18 to review facility QAPI activities.	

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F 867	Continued From page 50 Nurse Consultant on 5/25/18 at 2:55pm revealed that medication storage was a building issue during last year's survey. The Regional Nurse Consultant stated during that survey, the building was in the process of relocating the medication storage rooms. The Regional Nurse Consultant verbalized that expired medications were on the cart and they should not have been. F688 Increase/ prevent Decrease in ROM/ Mobility: Based on observations, record review and resident and staff interviews the facility failed to apply a left ankle/ foot orthotic (AFO) recommended by physical therapy to be worn daily for up to 8 hours for 1 of 4 residents (Resident #50) observed for range of motion. An interview with the Administrator on 5/25/18 at 2:57pm revealed that the restorative program was not functional at this time. The Administrator stated that the team just met (May 2018) and developed a Performance Improvement Plan (PIP) to address this area. F812 Food Procurement, Store/ Prepare/ Serve-Sanitary: Based on observations and staff interviews, the facility failed to use beard guards for 2 of 2 male staff involved in food preparation. Additionally, the facility failed to store clean dishes to air dry, monitor produce (kale and bell peppers) for signs of spoilage, and store ice cream 0 degrees Fahrenheit or below for 2 of 3 cold storage units observed. An interview with the Administrator on 5/25/18 at	F 867	Administrator provided education to the QAPI committee on Performance Improvement Plans and the expectation for continued improvement in areas below expectation. The current performance improvement plans for Restorative and Dietary storage and serving were revised to add the concerns identified during the survey during the 6-15-18 QAPI meeting. The QAPI committee agreed that the medication was stored securely as identified in the previous plan, but initiated a new Performance Improvement Plan to include the discarding of expired medications. The QAPI committee will continue to use audits and data to determine areas below expectation and implement Performance Improvement Plans as indicated. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Administrator will continue to work with the Quality Improvement Organization on best practices for QAPI and Performance Improvement. The administrator will send the minutes of the QAPI committee meetings to the corporate quality assurance nurse for review and recommendations. The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of	

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F 867	Continued From page 51 2:59pm revealed that the facility has addressed some of the areas regarding the kitchen and this was evident by the improvement in recent health department sanitation scoring. An interview with the Administrator on 5/25/18 at 3:00pm verbalized there were no open plans of corrections from the previous annual survey. She further stated that she began at the facility in October 2017. The Administrator verbalized that she reviewed any QAPI (Quality Assurance Performance Improvement) information that she could locate. The Administrator revealed that her expectation regarding QAPI was to continue seeing improvement with her current team. The information reviewed would be data driven. The Administrator further stated that she expected her team to continue working the Performance Improvement Plans (PIPs) that have been brought forward and any new areas identified.	F 867	correction by 6-25-18.	
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		6/25/18

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F 880	Continued From page 52 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 53 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observations, physician, and staff interviews the facility failed to follow safe practices for disinfecting a shared glucometer and performing handwashing during a medication pass for 5 of 5 residents (Resident # 73, Resident #72, Resident #67, Resident #74, and Resident #223). In addition, the facility failed to transport a used blood glucose test strip safely by placing the test strip in a scrub top pocket containing clean and dirty supplies for 2 of 2 residents (Resident #47 and Resident #36). The failed practices were observed with 6 of 30 residents who had physician ordered blood glucose monitoring and had the potential to expose the residents to the risk for cross-contamination of bloodborne pathogens (Resident #47, Resident #73, Resident #72, Resident #67, Resident # 74, and Resident #223). Immediate Jeopardy began on 5/23/18 when Nurse #1 was observed during a medication pass to transport a blood sample test strip used on Resident #36 during blood glucose monitoring in his right scrub top pocket commingled with clean and dirty supplies that included a nebulizer treatment that would be later administered to	F 880	The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. " During the analysis of the deficient practice of Nurse #1, the nurse admitted to not following proper procedure by placing the glucometer strip for Resident #36 in his scrub pocket comingled with supplies for Resident #47. " During the analysis of the deficient practice of Nurse #2, the nurse denied being trained on the cleaning of glucometers despite being presented with her signed acknowledgement of blood borne pathogens training on 4-18-18. The nurse expressed to her direct supervisor that she knew to clean the glucometers but thought alcohol wipes were the appropriate product for cleaning. Upon review of the nurse□s medication cart, the appropriate supplies were available; there were two glucometers and the Sani-Wipes in a box in the bottom drawer of the cart for the disinfection of the glucometers. " During the analysis of the deficient	

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F 880	Continued From page 54 Resident #47. On a separate medication pass observation Nurse #2 was observed not disinfecting a shared glucometer while collecting blood samples for blood glucose readings from 5 residents (Resident 73, Resident #72, Resident #67, Resident #74, and Resident #223). The Immediate Jeopardy was removed on 5/25/18 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (pattern with no actual harm with potential of more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to disinfecting glucometers, transporting supplies exposed to blood, and preventing transmission of bloodborne pathogens. Findings included: 1. A review of a facility policy for Patient Care Equipment dated 12/26/17, Section 13, titled, "Glucometers" read in part, Clean the outside of the meter using a lint-free cloth. Clean in accordance with manufacturer's recommendation. A review of the manufacturer's guidelines noted in the User Instruction Manual revised on 1/17, titled, "Maintenance, Cleaning and Disinfecting Guidelines" read in part, Healthcare professionals should wear gloves when cleaning the meter. Wash hands after taking off gloves. Contact with blood presents a potential infection risk. We suggest cleaning and disinfecting the meter between patient use. Cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant detergent or	F 880	practice of Nurse #3, she expressed to her direct supervisor that she knew to clean the glucometers between patients, but thought alcohol wipes were appropriate for cleaning. " On 5/23/18 Nurse # 1 was noted to enter a resident room with blood glucometer supplies and insulin during a medication administration pass. After the blood glucose level was checked, Nurse #1 realized that he needed more insulin from his cart. He then proceeded to gather the supplies which included: glucometer, used testing strip, gloves, insulin vial, insulin syringe, insulin pen needle, insulin pen, and alcohol prep pads. He then placed them all into his scrub right pocket. " Nurse #2 failed to follow infection control practices and four residents have the potential to be affected by the deficient practice of Nurse #2, Residents #72, 74, 67, 223. Nurse #2 violated the facility infection control policy by not cleaning the glucometer after obtaining Resident #73 accucheck, as she was trained during her orientation. Nurse #2 was also observed not sanitizing her hands between glove changes. Nurse#2 was immediately removed from patient care, and in-serviced; nurse #2 is no longer employed by the facility and was reported to the board of nursing. " Nurse #3 expressed knowledge of the wrong cleaning supply by using alcohol wipes after the completion of an accucheck. Nurse #3 was in-serviced immediately and returned to patient care as soon as she verbalized correct	

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F 880	Continued From page 55 germicide wipe. A review of the PDI Sani Cloth Bleach Germicidal Disposable Wipe manufacturer guidelines read in part, to disinfect: unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full 4 minutes. Use an additional wipe(s) if needed to assure continuous 4 minute wet contact time. A review of a facility policy for Handwashing Requirements dated 12/26/17, Section A, titled, "Hand Hygiene" read in part, situations that require hand hygiene: before and after performing any invasive procedure (e.g. fingerstick blood sampling). a. A review of the admission MDS dated 5/8/18 for Resident #73 was coded moderate impairment for cognitive skills for daily decision making. Diagnoses coded included diabetes and paranoid schizophrenia. A physician order for Resident #73 revealed an order dated 5/11/18 that read, Obtain stool sample to rule out C Difficile (clostridium difficile, a bacteria that causes an inflammation of the colon. The bacteria spreads by contact with a contaminated object or surface). A physician order for Resident #73 revealed an order dated 5/12/18 that read, Give Metronidazole (Flagyl, used to treat C Difficile) 500mg three times daily until 5/23/18. A review of a critical lab result dated 5/12/18 for Resident #73 revealed detected toxigenic C. difficile.	F 880	cleaning procedures, return demonstration, and a quiz following the education to determine knowledge retention. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. " The facility will continue the plan of correction initiated on 5-23-18. " Facility nursing staff are being in-serviced beginning on 5-23-18 on the policy on Patient Care Equipment including: use of PDI Sani-Wipes, and wet time. Facility nursing staff are being in-serviced beginning on 5-23-18 on the policy Handwashing Requirements. Facility nursing staff also acknowledged by signature the understanding of transmission precautions and that proper hand washing and glucometer disinfecting was required to prevent the transmission of blood borne pathogens. Education was provided by DON, unit managers, and Regional Nurse Consultant. New hires will be educated during general orientation by nursing administration, which will be confirmed by the administrator before they can independently provide glucose checks. Nursing staff will be in-serviced before returning to work " The medical director, and physician, for Residents #73, 72, 74, 67, and 223 was notified on 5-23-18 of the deficient practice of the nurses by the Administrator and the Regional Nurse Consultant. RN	

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F 880	Continued From page 56 During a medication pass observation on 5/23/18 at 4:48pm Nurse #2 stated she had obtained the blood sample for blood glucose monitoring from Resident #73 in her room. Nurse #2 was observed holding the glucometer with a blood glucose result that read 223. Nurse #2 then prepared heparin (a blood thinner injection) and a Humalog (insulin used to treat diabetes) syringe for administration for Resident #73. Nurse #2 was observed to place new gloves on for preparation of the medications and then removed her gloves before entering Resident #73's room. New gloves were placed on for administering the medications for Resident #73 and then removed before exiting the room. Nurse #2 walked back to her medication cart and placed new gloves on for the next resident, Resident #72, who was scheduled to have blood glucose monitoring. There were 2 glucometers observed sitting on the medication cart and the same glucometer was chosen to be used for the next assigned resident, Resident #72. No handwashing or disinfecting the glucometer was observed. b. A review of the admission MDS dated 1/16/18 was coded indicating Resident #72 had intact cognition. Diagnoses coded included diabetes and brain stem stroke syndrome. An observation on 5/23/18 at 4:52pm with Nurse#2 revealed she gathered an alcohol swab, lancet, test strip, and the shared glucometer used for Resident #73 from her medication cart on Hall 100. Nurse #2 placed a new test strip in the shared glucometer and went into the room where Resident #72 resided to collect a blood sample for blood glucose monitoring. The glucometer read 116. Nurse #2 left the room and read the sliding scale physician order from the Electronic	F 880	assessment of all five residents has not shown any change in condition potentially caused by the deficient practice of the nurses. The physician agreed to order Hepatitis and HIV panels on all five residents to rule out the diagnosis of any new blood borne pathogens; all five residents refused to comply with the physician orders and would not permit the labs to be drawn. Each resident was educated, re-approached, and still refused the testing. The health department was notified and reviewed the national database for Hepatitis and HIV and found no indications of previous infection by any of the five residents. The health department was notified, of the second refusal by three of the residents and the discharge of two of the residents, and stated the facility did not need to pursue the labs since the database was negative. The facility will notify the health department if any signs or symptoms of Hepatitis or HIV presents in any of the patients by November 2018. " Nurse #1 was pulled off the cart immediately to discuss the deficient practice for infection control and possible cross contamination. Nurse #1 was then sent home and no longer is an employee of the facility. " No other nurses were identified as placing supplies with potential blood borne pathogens comingled into scrub pockets. " The responsible parties were notified of the deficient practice by the nurses in the performance of the care of the six residents on 5-25-18. " The facility contacted the QIO on 5-25	

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F 880	Continued From page 57 Medication Administration Record (eMAR), O units were needed. Nurse #2 was not observed disinfecting the glucometer. Nurse #2 was observed removing her gloves used during the blood glucose check and placing new gloves on for the next resident, Resident #67, who was scheduled to have blood glucose monitoring. There were 2 glucometers observed sitting on the medication cart and the same glucometer was chosen to be used for the next assigned resident, Resident #67. No handwashing was observed. c. A review of the admission MDS dated 4/25/18 was coded indicating Resident #67 had moderate cognitive patterns. Diagnoses coded included diabetes, hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side. An observation on 5/23/18 at 4:57pm with Nurse #2 revealed she gathered an alcohol swab, lancet, test strip, and the same glucometer used for Resident #72 from her medication cart on Hall 100. Nurse #2 placed the test strip in the glucometer and went into the room for Resident #67 to collect a blood sample for blood glucose monitoring. The glucometer read 240. Nurse #2 left the room and read the sliding scale for Novolog from the eMAR and stated Resident #67 would need 4 units of Novolog and 3 units of Humalog administered. Nurse #2 was not observed disinfecting the glucometer. She was observed taking off the gloves used during the blood sugar check and placing new gloves on to prepare both insulins for Resident #67. Nurse #2 administered the insulins via subcutaneous injection in the resident's room. Nurse #2 left the room and removed her gloves and then placed new gloves on for the next resident, Resident	F 880	-18 to request additional training on infection control and blood borne pathogens for facility staff; the QIO representative for the Charlotte area agreed to meet with the facility on 5-29-18; however, the meeting was rescheduled. The Administrator and DON met with the QIO representative on 6-13-18. " The director of nursing reported Nurse #1 and Nurse #2 to the local health department and the board of nursing on 5-25-18; both nurses are no longer employed by the facility. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements " Education was provided by the Regional Nurse Consultant to the Director of Nursing and Unit Managers with return demonstration on the cleaning and disinfecting process for glucometers per manufacturer guidelines on 5-24-18. " The Administrator spoke with the local health department on 5-29-18 regarding the glucometer breach; there were no further recommendations. Administrator also met with the local health department at the facility on 6-7-18 to review the glucometer breach and the plan of correction with no further recommendations provided by the health department except to notify the health department if any signs or symptoms of Hepatitis or HIV presents in any of the patients by November 2018.	

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F 880	Continued From page 58 #74, who was scheduled to have blood glucose monitoring. There were 2 glucometers observed sitting on the medication cart and the same glucometer was chosen to be used for the next assigned resident, Resident #74. No handwashing was observed. d. Resident #74 was admitted on 5/17/18 with diagnosis that included altered mental status and past medical history of dementia, hypertension, diabetes, and pulmonary hypertension. During an observation on 5/23/18 at 5:06pm, Nurse #2 gathered an alcohol swab, lancet, test strip, and the same shared glucometer used for Resident #73, Resident #72, and Resident #67. Nurse #2 placed a test strip in the shared glucometer and went to the room for Resident #74 to collect a blood sample for blood glucose monitoring. The glucometer read 268. Nurse #2 walked to her medication cart to read the sliding scale from the eMAR. The order read to administer 4 units. Nurse #2 was not observed disinfecting the glucometer. She was observed taking off the gloves used during the blood sugar check and putting on clean gloves before proceeding to prepare the insulin needed for Resident #74. Nurse #2 administered the insulins via subcutaneous injection in the resident's room. Nurse #2 left the room and removed her gloves. No handwashing was observed. During an interview on 5/23/18 at 5:10pm, Nurse #2 if stated she had not been washing her hands in between removing gloves and placing new gloves on. Nurse #2 explained she had been so nervous that she had forgotten. Nurse #2 indicated she knew how essential it was to wash her hands when taking off gloves to put on new	F 880	" Beginning on 5-25-18, random audits will be conducted to ensure glucometer cleaning is performed per facility policy and manufacturer instructions Audits will be done 5 times weekly x 2 weeks, 3 times weekly x 2 weeks, and then once weekly x 2 months. Audits will be performed by Director of Nursing, Unit managers, Regional Nurse Consultant or designee. The nurse consultant will review the audits with the Director of Nursing and the Administrator who will report findings to the QAPI committee. The title of the person responsible for implementing the acceptable plan of correction Director of Nursing and Infection Control Preventionist with completion by 6-25-18.	

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gloves. She then sanitized her hands with the hand gel stored on top of her medication cart and put on new gloves for the next resident, Resident #223, who was scheduled to have blood glucose monitoring. There were 2 glucometers observed sitting on the medication cart and the same glucometer was chosen to be used for the next assigned resident, Resident #223.

e. Resident #223 was admitted on 5/12/18 with diagnoses that included hypertension, diabetes, Alzheimer's disease, and adult failure to thrive.

During an observation on 5/23/18 at 5:12pm, Nurse #2 gathered an alcohol swab, lancet, test strip, and the same glucometer that had been used for Resident #73, Resident #72, Resident #67, and Resident #74. Nurse #2 placed the test strip in the shared glucometer and walked to the room for Resident #223 to collect a blood sample for blood glucose monitoring. The glucometer read 169. Nurse #2 walked to her medication cart and threw away the used lancet in the sharps container and began to place the shared glucometer back in her medication cart. Nurse #2 was not observed disinfecting the glucometer. She was observed taking off the gloves used during the blood sugar check. No handwashing was observed after removing her gloves.

During an interview on 5/23/18 at 5:18pm, Nurse #2 stated she had not disinfected the shared glucometer used during collecting blood samples for the blood glucose monitoring for Resident #73, Resident #72, Resident #67, Resident #74, and Resident #223. She indicated her practice was to disinfect the shared glucometer when supplies were available. Nurse #2 explained she did not disinfect the shared glucometer if supplies

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were not available. Nurse #2 stated she had worked on Monday, 5/21/18, on the same assignment during the shift of 3-11pm and did not have alcohol wipes on the cart so she did not disinfect the glucometer for any of her assigned residents on that night either.

During an observation on 5/23/18 at 5:18pm, Nurse #2 was observed asking Nurse#3 how the shared glucometer was to be disinfected. Nurse #3 instructed Nurse #2 to disinfect the glucometer with an alcohol wipe for 2 minutes. Nurse #2 walked back to her cart, found alcohol wipes and wiped the used glucometer.

During an observation on 5/23/18 at 5:27pm, Nurse #2 walked to the office by the nurse's station on Hall 100 and asked the Director of Nursing (DON) and Unit Manager (UM) #1 how to disinfect a shared glucometer. Both the DON and UM#1 instructed Nurse #2 to use a sani wipe for 2 minutes and together walked back to the cart with Nurse #2 to assist.

During an observation on 5/23/18 at 5:27pm, UM#1 and the DON were observed educating Nurse #2 on how to disinfect the glucometer. The sani wipes were observed to be located on the bottom drawer of the medication cart. The observed instructions given by the DON and UM #1 to Nurse #2 was to wipe the glucometer off for 2 minutes with a PDI (PDI Sani Cloth Bleach Germicidal Disposable Wipe) wipe, then air dry for 1 minute, then dry off any leftover chemical on the device and to follow the steps after every use of the shared glucometer. During the education both the DON and UM #1 gave reminders to Nurse #2 regarding washing hands between taking off gloves and putting on new gloves.

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F 880	Continued From page 61 An interview on 5/23/18 at 5:35pm with Nurse #2 revealed she had never been told how to disinfect a glucometer and had not received formal orientation. Nurse #2 explained, since she had worked at the facility for the last 3 weeks, she had used alcohol wipes to disinfect the glucometer when it had been available. Nurse #2 indicated she had just moved from another state and was taught to disinfect glucometers with alcohol there. An interview on 5/23/18 at 5:50pm with the Nurse Consultant revealed she had in-serviced all of the nurses on the correct procedure for disinfecting glucometers right after the medication pass observation with Nurse #2. The Nurse Consultant indicated the nurses knew the PDI wipes were located on their medication carts and available stock was on hand. She stated the contact time for the PDI wipe was 4 minutes. An interview on 5/23/18 at 6:13pm after observation of a medication pass with Nurse #3, revealed she had been in-serviced about 15 to 20 minutes ago and was told to use alcohol wipes for 4 minutes now instead of 2 minutes as before to disinfect the glucometers. She stated she had used chlorhexidine wipes in the hospital but since the facility did not have that she had used what was available, alcohol wipes. Nurse #3 indicated she had not received formal training and had only worked in the facility for 3 weeks. She explained the only in-service she had received since working in the facility had been on falls. Nurse #3 explained she had received a Human Resources (HR) employee handbook but nothing about glucometers. During an interview with the Administrator on	F 880		

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F 880	Continued From page 62 5/23/18 at 7:40pm she revealed Nurse #3 was a return employee to the facility from 1 year ago and had not received formal training. She indicated that Nurse #1, Nurse #2, and Nurse #3 had all received training and should have known correct handwashing procedures and how to disinfect the shared glucometers as part of their training. An interview on 5/24/18 at 9:19am with the facility Medical Director was conducted via the telephone. During the interview, the Medical Director revealed a breach in infection control due to absence of disinfection of the glucometers in his prospective was absolutely concerning. Universal Precautions were to be used regardless if a resident such as Resident #73 had C Difficile or not. He explained the risk for cross-contamination was always there. The Medical Director further explained that we may not know if a resident had Hepatitis B or Hepatitis C and mandatory precautions were to be used always. In regard to Resident #73 with diagnosis of C Difficile as the first resident to have blood sugar checks, insulin injected, and heparin injected on an assignment for Nurse#2, the potential for harm was most certainly there. He revealed Resident #73 had extensive psych issues and had been difficult to manage during her treatment of C Difficile. The Medical Director added the possibility for C Difficile spores on her hands was probable. The Medical Director stated the need for training for all nurses including new hires was imperative. He explained the facility needed to set the standards from Day 1 regarding all nursing education including handwashing and disinfecting glucometers. The Medical Director revealed Staff Development Coordinator (SDC) who was responsible for educating the staff had	F 880		

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left about 2 weeks previous and had given her notice 2 to 3 weeks before her last day. During the last 5 to 6 weeks while the SDC worked in the facility, she was pulled to a medication cart due to nurse call-outs sometimes 15 to 20 minutes prior to a shift. At the same time nurses were let go by the facility for not meeting professional standards. It had been a bad time for staffing he explained. The Medical Director revealed the SDC had been physically in the building but could not train staff because she kept getting pulled to a cart. As far as Nurse #2 and Nurse #3 using alcohol wipes versus a germicidal for a shared glucometer between residents, was an important distinction. The Medical Director explained a germicidal must be used for a shared glucometer and the only time alcohol would be acceptable was if each resident had their own glucometer and were individually bagged and labeled. He added, disinfecting supplies have to be made available to the staff in order to take care of the residents.

An interview on 5/25/18 at 9:52am with the SDC was conducted via the telephone. The SDC revealed she was on vacation and had planned on returning to the facility in the role of a MDS Coordinator. She indicated glucometer disinfection was taught during the Bloodborne Pathogen PowerPoint verbally on the third day of orientation. Handwashing training was taught during the Bloodborne Pathogen PowerPoint presentation, during infection control, and multiple times during orientation. New hires were given written and verbal education but no return demonstrations were included in the training. She indicated rounds by the SDC and Department heads included monitoring handwashing technique and real time education was provided with any negative observations.

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The SDC stated she had not rounded on Nurse #2 or Nurse #3 since both were new employees. The SDC stated she expected nurses to wash their hands before putting on new gloves, disinfect the glucometer, and then the nurse should use the second glucometer on the medication cart for the next resident until the 4 minute contact time for the PDI wipes had expired.

During an interview on 5/25/18 at 11:07am, the Administrator stated it was her expectation for the staff to follow facility policy and manufacturer guidelines in regards to disinfecting shared glucometers and handwashing after the removal of gloves. The Administrator revealed the Regional Manager had included UM #1 and the DON in the training related to correctly disinfecting the glucometers due to both giving incorrect directions to Nurse #2 on 5/23/18.

2. A review of a facility policy for Infection Control Policies and Procedures dated 2/01/15, Section C, 2., read in part, Unit Managers assure that staff follows infection control procedures to maintain patient safety. Section C, 6., Equipment will be disposed of or properly disinfected.

a. A review of the admission Minimum Data Set (MDS) dated 4/9/18 for Resident #47 was coded for moderate cognitive status and her staff assessment for mental status could not be conducted. Diagnoses coded included diabetes, acute and chronic respiratory failure with hypoxia, COPD, and anxiety disorder. Resident #47 was coded as receiving Hospice services.

An observation on 5/23/18 at 9:00am on Hall 200 for cart #2 revealed Nurse #1 placed a nebulizer

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treatment for Resident #47 in the right pocket of his scrub's to be administer at a later time.

On 5/23/18 at 9:20am Nurse#1 was observed as he reached into his right scrub top pocket for the scheduled nebulizer treatment to be administered to Resident #47. He placed the nebulizer face mask on Resident #47 and started the treatment using the nebulizer treatment from his right pocket. The nebulizer was observed commingled with used gloves, clean gloves, a used test strip with a blood specimen, a used lancet, alcohol wipes, gloves, the dirty glucometer, an insulin syringe, a vial for Humalog, a Levemir Flexpen, a pen needle inserted with a cap, and an ink pen.

b. A review of the annual MDS dated 1/1/18 for Resident #36 was coded for intact cognition and independent with activities of daily living. Diagnoses coded included diabetes, major depressive disorder, and anxiety disorder.

On 5/23/18 at 9:01am Nurse #1 was observed to gather alcohol wipes, gloves, a lancet, glucometer, insulin syringe, a vial of Humalog (insulin used to treat diabetes), a Levemir Flexpen (insulin), and pen needle and then placed the supplies in his right scrub top pocket. Nurse #1 walked down the hall to Resident #36's room and took out the alcohol wipes, gloves, lancet, glucometer, insulin syringe, vial of Humalog, Levemir Flexpen and pen needle. Nurse #1 then placed the supplies on the dresser for Resident #36. Nurse #1 collected a blood sample to test the blood glucose from the resident's forefinger. He then squeezed the drop of blood onto blood glucose test strip. The glucometer read the blood glucose to be 282. Resident #36 asked what was his blood sugar

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and Nurse #1 stated, "I'm sorry I need to get another Levemir Flexpen since I do not have enough in the Flexpen I brought." Nurse #1 then gathered the used gloves, the clean gloves, used test strip with the blood drop, the used lancet, alcohol wipes, gloves, the dirty glucometer, insulin syringe, vial for Humalog, Levemir Flexpen, and pen needle inserted with a cap. Nurse #1's right scrub top pocket was noted to have 1 ink pen, the nebulizer treatment for Resident #47, and all the above items for Resident #36.

On 5/23/18 at 9:25am Nurse #1 was observed to grab a new Levemir pen from the medication room on Hall 200, labeled the pen, and placed the new pen in his right scrub top pocket as he walked back down the hall for Resident #36. Once in the room for Resident #36, Nurse #1 stated he had picked up the wrong pen and still did not have enough insulin for the ordered 95units of Levemir after combining 2 separate Flexpens. Again, he gathered all supplies, put them in his right pocket and walked back to his medication cart at the end of the hall. He opened the top drawer of the medication cart #2 and walked back to the room for Resident #36. After administering both injectable pens of Levemir to Resident #36, Nurse #1 put clean gloves from his left pocket into his right pocket where the dirty items were stored. Nurse walked to medication cart and disposed of the used items from his right scrub top pocket.

An interview with Nurse #1 on 5/23/18 at 9:35am revealed he had put all of the supplies into his right pocket including the used test strip, once he had entered the room after checking the blood glucose and realized he did not have enough

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insulin to administer to Resident #36. Nurse #2 stated he had a heavy assignment with 26 residents including 7 insulin administrations. Nurse #1 indicated there was no one to ask for help when needed. He stated he had received no job training before his first shift when he was assigned to a medication cart. Nurse #1 explained Nurse #4 who no longer worked at the facility, pulled the medications and he had administered the medications to the residents during his first shift in the facility.

An interview with the Administrator was conducted on 5/23/18 at 3:27pm. The Administrator indicated it was her expectation that Nurse #1 would have put the used items inside his glove to keep from the clean items until Nurse #1 could discard the collected blood sample on the test strip into a sharps container. She stated Nurse#1 had been trained by the Staff Development Coordinator (SDC) and had received ongoing training on time management and consolidating methods to use during a medication pass. The Administrator was unable to provide any evidence of specific training given to Nurse #1.

An interview on 5/25/18 at 9:52am with the SDC via telephone revealed she personally had been on the floor with Nurse #1 and also rounded on him and had never seen Nurse #1 transport a used blood sample test strip in his pocket. The SDC stated she had expected for nurses to take a small sharps container into the room and they should absolutely not put a used test strip in their scrub pocket. She reiterated, "Nothing goes in the pocket, the strip goes directly into the sharps container".

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On 5/24/18 at 3:32pm, the Administrator and Nurse Consultant were informed of Immediate Jeopardy for F880.

On 5/25/18 at 3:52pm, record review revealed the specific Skills Competency Validation Record for nurses regarding resident care located in the facility assessment notebook had not been completed for Nurse #1, Nurse #2, and Nurse #3.

On 5/25/18 at 4:32pm, the facility provided the following Credible Allegation of Immediate Jeopardy removal.

The plan of correcting the specific defiency. The plan should address the processes that led to the deficiency cited.

During the analysis of the deficient practice of Nurse #1, the nurse admitted to not following proper procedure by placing the glucometer strip for Resident #36 in his scrub pocket comingled with supplies for Resident #47.

During the analysis of the deficient practice of Nurse #2, the nurse denied being trained on the cleaning of glucometers despite being presented with her signed acknowledgement of blood borne pathogens training on 4/18/18. The nurse expressed to her direct supervisor that she knew to clean the glucometers but thought alcohol wipes were the appropriate product for cleaning. Upon review of the nurse's medication cart, the appropriate supplies were available; there were two glucometers and the Sani-Wipes in a box in the bottom drawer of the cart for the disinfection of the glucometers.

During the analysis of the deficient practice of

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Nurse #3, she expressed to her direct supervisor that she knew to clean the glucometers between patients, but thought alcohol wipes were appropriate for cleaning.

On 5/23/18 Nurse #1 was noted to enter a resident room with blood glucometer supplies and insulin during a medication administration pass. After the blood glucose level was checked, nurse #1 realized that he needed more insulin from his cart. He then proceeded to gather the supplies which included: glucometer, used testing strip, gloves, insulin vial, insulin syringe, insulin pen needle, insulin pen, and alcohol prep pads. He then placed them all into his scrub right pocket.

Nurse #2 failed to follow infection control practices and four residents have the potential to be affected by the deficient practice of Nurse #2, Residents #72, 74, 67, 223. Nurse #2 violated the facility infection control policy by not cleaning the glucometer after obtaining Resident #73 accucheck, as she was trained during her orientation. Nurse #2 was also observed not sanitizing her hands between glove changes. Nurse#2 was immediately removed from patient care, and in-serviced; any further demonstration of incompetent practices will result in immediate termination.

Nurse #3 expressed knowledge of the wrong cleaning supply by using alcohol wipes after the completion of an accucheck. Nurse #3 was in-serviced immediately and returned to patient care as soon as she verbalized correct cleaning procedures, return demonstration, and a quiz following the education to determine knowledge retention.

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F 880	Continued From page 70 The procedure for implementing the acceptable plan of correction for the specific deficiency cited. Facility nursing staff are being in-serviced beginning on 5/23/18 on the policy on Patient Care Equipment including: use of PDI Sani-Wipes, and wet time. Facility nursing staff are being in-serviced beginning on 5/23/18 on the policy Handwashing Requirements. Facility nursing staff also acknowledged by signature the understanding of transmission precautions and that proper hand washing and glucometer disinfecting was required to prevent the transmission of blood borne pathogens. Education was provided by DON, unit managers, and Regional Nurse Consultant. New hires will be educated during general orientation by nursing administration which will be confirmed by the administrator before they can independently provide glucose checks. Nursing staff will be in-serviced before returning to work The medical director, and physician, for Residents #73, 72, 74, 67, and 223 was notified on 5/23/18 of the deficient practice of the nurses by the Administrator and the Regional Nurse Consultant. RN assessment of all five residents has not shown any change in condition potentially caused by the deficient practice of the nurses. The physician agreed to order Hep B and HIV panels on all five residents to rule out the diagnosis of any new blood borne pathogens in the five residents. The local health department will be notified if there are lab results indicating that transmission of a blood borne pathogen has occurred. Nurse #1 was pulled off the cart immediately to discuss the deficient practice for infection control	F 880		

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and possible cross contamination. Nurse #1 was then sent home and no longer is an employee of the facility.

No other nurses were identified as placing supplies with potential blood borne pathogens comingled into scrub pockets.

The responsible parties were notified of the deficient practice by the nurses in the performance of the care of the six residents on 5/25/18.

The facility contacted the QIO on 5/25/18 to request additional training on infection control and blood borne pathogens for facility staff; the QIO representative for the Charlotte area agreed to meet with the facility on 5/29/18.

The director of nursing reported Nurse #2 and Nurse #3 to the local health department and the board of nursing on 5/25/18.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements

Education was provided by the Regional Nurse Consultant to the Director of Nursing and Unit Managers with return demonstration on the cleaning and disinfecting process for glucometers per manufacturer guidelines on 5/24/18.

Beginning on 5/25/18, random audits will be conducted to ensure glucometer cleaning is performed per facility policy and manufacturer instructions Audits will be done 5 times weekly x 2 weeks, 3 times weekly x 2 weeks, and then

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once weekly x 2 months. Audits will be performed by Director of Nursing, Unit managers, Regional Nurse Consultant or designee. The nurse consultant will review the audits with the Director of Nursing and the Administrator who will report findings to the QAPI committee.

The title of the person responsible for implementing the acceptable plan of correction:

Director of Nursing and Infection Control Preventionist with completion by 5/25/18.

Immediate Jeopardy was removed on 5/25/18 at 6:34pm when observations and interviews revealed nurses were knowledgeable about disinfecting glucometers, handwashing safe practices, and transporting used blood glucose test strips safely to a sharps container. Nurses demonstrated how to obtain blood glucose readings and disinfecting glucometers after each use as recommended by the manufacturer's instructions on the wipes provided by the facility.