STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345417	A. BUILDING _____ B. WING _____	C 09/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27588

(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 The facility's annual recertification survey and complaint investigation was conducted on 9/18/18 through 9/21/18 (Event ID #459B11). The survey exit date was extended to 9/25/18 for the completion of a physician's telephone interview.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would	F 623		10/12/18

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

Electronically Signed | 10/11/2018

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F 623	Continued From page 1	F 623		

be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental

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F 623	Continued From page 2 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the family member and the Ombudsman in writing when 2 of 2 sampled residents (Residents # 126 and 113) were discharged to the hospital. The findings included: 1. Resident # 126 was admitted to the facility on 5/29/18 with diagnoses including right artificial hip joint, Coronary Artery Disease and Chronic Obstructive Pulmonary Disease.	F 623	This plan of correction constitutes a written allegation of compliance, preparation, and submission of the plan of correction does not constitute admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of requirement under state and federal law. Corrective Action for those residents that have been affected.	

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F 623	Continued From page 3 A review of Resident #126 ' s admission Minimum Data Set (MDS) identified him as having moderately impaired cognition. A review of Resident # 126 ' s medical record revealed he was sent to the hospital on 6/27/18 for evaluation after his Xray revealed he had pulmonary edema and pleural effusion. No written notice of transfer was documented to have been provided to the resident, his responsible party (RP) or the Ombudsman. During an interview on 9/20/18 at 1:57 AM the social worker (SW) stated that they did not notify the Ombudsman when a resident was sent out to the hospital. She stated the responsible party (RP) was called to notify them the resident had been sent to the hospital. During an interview on 9/20/18 at 2:25 PM the 100 hall nurse stated they called the RP to notify them the resident was sent to the hospital and document the call in the resident ' s medical record. During an interview with the Director of Nursing (DON) on 9/20/18 at 2:58 PM she stated they notify the family, RP via phone and document in the resident ' s medical record the reason for discharge to the hospital. She stated they did not send a letter to the family or RP as they document in the medical record the reason for discharge to the hospital. The DON stated they did not notify the Ombudsman when a resident is discharged to the hospital. During an interview on 9/20/18 at 3:39 PM the Administrator stated that they called the family or RP to inform them the resident was discharged to	F 623	On 8/20/18 in review of the medical records it was observed that the Family of resident 125 & 113 were notified via telephone calls of a transfer to the hospital. However, there was not written communication to the responsible party or family regarding the date sent, the reason for the discharge and the location to where the residents were sent. The ombudsman was not notified in writing of these discharges. Corrective action will be accomplished for those residents to be affected by the same deficient practice. On 9-27-18 the Administrator educated the Business Office Manager was educated on sending written documentation to the responsible party regarding: the reason for the discharge, the date of the discharge, and the location to where they resident was sent. On 9/27/18 the Administrator educated Social Workers were educated on sending written documentation to the Ombudsman regarding a discharge from the facility. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. The Business manager or her designee will document 100% of the discharge and transfers in written communication to the family member or responsible party on the	

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F 623	Continued From page 4 the hospital and document the call in the resident ' s medical record. He revealed they did not notify the Ombudsman when a resident was discharged to the hospital. 2.Resident # 113 was admitted to the facility on 5/29/18 with cumulative diagnoses which included Alzheimer's dementia with behavioral disturbances, psychosis and cerebral vascular accident with left sided weakness. Review of the annual Minimum Data Set (MDS) assessment dated 7/13/18 coded the resident with severely impaired cognition. Record review of the departmental notes revealed Resident #113 was transferred to the hospital on 8/21/18 due to vomiting and abdominal discomfort. No written notice of transfer was documented to have been provided to the Ombudsman. During an interview on 9/20/18 at 1:57 AM the social worker (SW) stated that they did not notify the Ombudsman when a resident was sent out to the hospital. During an interview with the Director of Nursing (DON) on 9/20/18 at 2:58 PM she stated the facility did not notify the Ombudsman when a resident was discharged to the hospital. During an interview on 9/20/18 at 3:39 PM the Administrator stated the facility does not notify the Ombudsman when a resident was discharged to the hospital.	F 623	audit tool. The audit tool includes the resident name, date of written communication, responsible party/family name, reason sent, place sent to, initials of individual documenting this information, and administrator initials (for when he reviews the tool weekly). The Social Workers will be responsible for notifying the ombudsman of 100% of the resident discharge to the hospital. This will be logged on the audit tool, which includes the Resident Name, date the information was faxed, verification of fax confirmation, initials of recorder, and administrator verification. This will be done weekly for ninety days. The Administrator will review both of the audit tool weekly for 90 days. The Facility Plans to Monitor its performance to make sure the solutions are sustained. The Administrator will review each audit tools weekly to verify the documentation is being done correctly and will present the findings to the Quality Assurance Performance Improvement Committee monthly for three months or until a pattern of compliance is obtained. This will be completed by 10/12/18.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641		10/12/18

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F 641	Continued From page 5 resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) Assessment for 1 of 1 residents reviewed for elopement from the facility (Resident 81). The findings included: Resident #81 was admitted to the facility on 3/1/18 and had a diagnosis of Dementia. The resident's Care Plan dated 3/1/18 noted the resident wandered due to cognitive impairment and to provide care for the wander guard twice a day. The Admission Minimum Data Set (MDS) Assessment dated 3/8/18 revealed Resident #81 had severe cognitive impairment and ambulated independently in the corridor with supervision. Section P0200 E noted a wander guard was not used for the resident. The Quarterly MDS dated 5/9/18 noted a wander guard was not used for Resident #81. The Quarterly MDS dated 8/9/18 noted a wander guard was not used for Resident #81. On 9/21/18 at 10:38 AM an interview was conducted with MDS Nurse #1 who stated she completed the resident's MDS. The MDS Nurse stated she was instructed to not code the wander guard on the MDS. The MDS Nurse stated she did not code a wander guard on the MDS for any of their residents with a wander guard. On 9/21/18 at 11:38 AM The Director of Nursing (DON) stated in an interview the wander guard was placed on Resident #81 upon admission and understood the wander guard was not to be coded on the MDS. On 9/21/18 at 12:03 PM an interview was conducted with the DON and the MDS	F 641	This plan of correction constitutes a written allegation of compliance, preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal Law. Corrective Action for those residents that have been affected. On 9/24/18 all residents with a wander guard had their assessment changed to reflect the appropriate coding within MDS. On this date 11 residents had a wander guard, and their assessment was corrected to reflect wander guard worn daily within section P of the MDS assessment. Corrective action will be accomplished for those residents to be affected by the same deficient practice. On 9/25/18 both Case Mix Director (Amanda Earp) and Case Mix nurse (Christine Frazier) were educated by the Administrator and DON on Section P for accuracy and coding. Residents with	

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F 641	Continued From page 6 Coordinator. The MDS Coordinator stated she understood if they had an alarm system on all the doors in the facility where an alarm sounded if any person exited the door, a wander guard was not to be coded on the MDS.	F 641	wander guard are reflected with the number 2 in section P0200E. This will be done for all wander guard resident assessments moving forward. Measures put into place or systemic changes made to ensure that deficient practice will not occur. 100% of wander guard assessments in sections P will be verified prior to closing by two nurses to ensure this accuracy continues. This will be logged as needed during the week, for ninety days on the audit tool. This tool has the following fields: resident name, Assessment Reference Date (ARD), both nurse signatures and date this was verified. The Administrator and/or the DON will review the audit tool weekly to ensure compliance. If there are no changes on any given week, this will be noted as well. The facility plans to monitor its performance to make sure solutions are sustained. The CMD will present the findings of the Audit Tool for the Section P to the Quality Assurance Performance Improvement Committee monthly for three months or until a pattern of compliance is obtained. This will be done by 10/12/18.	
F 658	Services Provided Meet Professional Standards	F 658		10/15/18

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F 658 SS=E	Continued From page 7 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to accurately transcribe and follow the dosing frequency of a medication as ordered by the physician for 1 of 4 residents reviewed for unnecessary medications (Resident #29). The findings included: Resident #29 was admitted to the facility on 7/2/18 from the community. His cumulative diagnoses included gastritis and gastroesophageal reflux disease (GERD). A review of the resident ' s admission medication orders (dated 7/2/18) included 20 milligrams (mg) famotidine (a medication used to treat acid reflux) to be given by mouth twice daily. A review of Resident #29 ' s admission Minimum Data Set (MDS) assessment dated 7/9/18 revealed he had severely impaired cognitive skills for daily decision making. The resident required supervision for eating, limited assistance for walking in his room and for toileting, extensive assistance for bed mobility, locomotion on and off the unit, dressing, and personal hygiene. Section I of the MDS assessment indicated Resident #29 ' s diagnoses included GERD.	F 658	This plan of correction constitutes a written allegation of compliance, preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal Law. Corrective Action for those residents that have been affected. On 9/20/18 it was observed that resident # 29 had an order for 20 mg of famotidine to be administered twice a day. The resident only received it one time daily, as the medication was not scheduled on the MAR to be given a second time on each day. on 9/20/18 the resident was assessed by the Nurse Practitioner, at that time it was determined that the resident could tolerate the medication one time daily. The order given to change the medication to one	

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F 658	Continued From page 8 A review of Resident #29 ' s July 2018 Medication Administration Record revealed he received 20 mg famotidine twice daily as prescribed from 7/3/18 to 7/31/18. The famotidine was scheduled to be given at 8:00 AM and 5:00 PM every day. A review of the resident ' s monthly Physician Orders for August 2018 included 20 mg famotidine to be given as one tablet by mouth twice daily for GERD (as initiated on 7/3/18). A review of Resident #29 ' s August 2018 Medication Administration Record revealed he received 20 mg famotidine only once daily at 8:00 AM from 8/1/18 to 8/21/18. The famotidine was not scheduled on the MAR to be given at 5:00 PM until 8/22/18. Resident #29 received 20 mg famotidine twice daily (at 8:00 AM and 5:00 PM) from 8/22/18 to 8/31/18. A review of the resident ' s monthly Physician Orders for September 2018 continued to include 20 mg famotidine to be given as one tablet by mouth twice daily for GERD (as initiated on 7/3/18). A review of Resident #29 ' s September 2018 Medication Administration Record revealed he received 20 mg famotidine only once daily at 8:00 AM from 9/1/18 up to the date of the review on 9/20/18. The famotidine was not scheduled to be given at 5:00 PM on the MAR. An interview was conducted on 9/20/18 at 9:30 AM with Nurse #8. Upon request, the nurse reviewed the resident ' s September 2018 MAR and confirmed the dosing of famotidine was only scheduled once daily at 8:00 AM. However, she acknowledged the instructions written on the	F 658	time daily. Corrective action will be accomplished for those residents to be affected by same deficient practice. On 10/1/18 all active MAR were reviewed by the DON, Unit Managers, Unit Coordinators, or the designee of the DON to ensure all that the frequency of medications was correct. Of the 126 residents Mars it was found that 30 frequency orders needed to be clarified and were done so at that time. On 10/5/18 the DON, Staff Development Coordinator, Clinical Supervisors, or the Designee of the DON, (s)began Education on the Frequency of medications administration began for nurses. On 10/1/18 of the 36 nurses employed 25 have completed the education. The additional nurses will have this completed by 10/15/18. Any nurse that has not received this education as of 10/15/18 must complete prior to the start of their next shift. This will be part of the New Nurse orientation education. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. The DON and/or her Designee(s) will review twenty MARs each week to ensure that Frequency of Medication	

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F 658	Continued From page 9 physician ' s orders indicated the resident was supposed to receive this medication twice daily. A review of the bubble pack card of famotidine dispensed by the pharmacy on 9/19/18 for the resident included instructions to take one tablet by mouth twice daily for GERD. An interview was conducted on 9/20/18 at 10:11 AM with Unit Manager #1. During the interview, the Unit Manager reported, "The second dose (of Resident #29 ' s famotidine) fell off somehow." She stated she would complete a medication error report related to the situation. An interview was conducted on 9/20/18 at 10:19 AM with the facility ' s Director of Nursing (DON). During the interview, the DON stated it appeared there was an error during the month end changeover resulting in Resident #29 ' s famotidine being given once daily instead of two times a day as ordered. The DON stated her expectation was for the nurse to read the order and administer the medication as ordered on the MAR. Upon inquiry, the DON identified the nurses who had checked the physician orders during the month end changeover from August to September 2018. She reported one of the nurses was on leave and would not be available for an interview. An interview was conducted on 9/20/18 at 11:04 AM with the facility ' s consultant pharmacist. During the interview, the pharmacist reported she had completed a medication regimen review for Resident #29 on 8/22/18. She thought the error on the famotidine ' s dosing frequency was caught and corrected when she conducted the review at that time.	F 658	Administration is documented correctly. This will be done for 4 weeks and then 15 MAR will be audited for 4 more weeks, and then 10 for the next four weeks. This will be documented on the audit tool. This audit tool will indicate the date, resident room, medication frequency, time(s) of medication , documented correctly on the MAR, comment section, and auditors initials. The facility plans to monitor its performance to make sure solutions are sustained. Director of Nursing will present the findings of MAR transcription to the Quality Assurance Performance Improvement committee monthly for three months or until a pattern of compliance is obtained. This will be completed on 10/15/18.	

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F 658	Continued From page 10 An interview was conducted on 9/20/18 at 3:35 PM with Nurse #9. Nurse #9 identified her hand-writing on Resident #29 ' s August MAR as the nurse who corrected the MAR to include twice daily dosing of the famotidine. She reported the pharmacist and/or the Unit Manager had requested the correction on 8/22/18. An interview was conducted on 9/20/18 at 3:45 PM with Nurse #2. Nurse #2 was identified as the nurse who completed the first check on Resident #29 ' s physician ' s orders on 8/31/18 during the month end changeover. Upon review of the orders and the September MAR, Nurse #2 stated, "It was over looked." She reported that normally such an error should have been caught and corrected. A telephone interview was conducted on 9/20/18 at 4:00 PM with the Nurse Practitioner (NP) who helped care for Resident #29. During the interview, the NP reported she had assessed the resident earlier that morning (9/21/18) after the medication error was brought to her attention. At that time, she decided to see if the resident continued to tolerate once daily dosing of the famotidine and stated she changed the order accordingly.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		10/12/18

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(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 689	Continued From page 11 accidents. This REQUIREMENT is not met as evidenced by: Based on record reviews, attending physician and staff interviews the facility failed to use a mechanical lifting device during Resident #120's transfer from bed to chair and the transfer back into the bed. This was evident in 1 of 7 residents reviewed for accidents. Findings included: Resident #120 was readmitted to the facility on 12/22/13 with numerous diagnoses which included osteoporosis, dementia, history of hip fracture, and diabetes mellitus. Review of the Quarterly Minimum Data Set (MDS) assessment dated 5/21/18 coded the resident with short and long-term memory loss and no behavior issues. Under functional status the MDS was coded as extensive assistance of 2 staff for transfers. Review of the written care plan (undated) revealed a problem of osteoporosis, and at risk for fractures with an approach to use a mechanical lift for transfers. Another identified problem was falls with the approach for total lift for transfers. Interview on 09/20/18 at 2:58 PM with Unit Manager (UM) #1 stated on 7/18/18, NA #1 was looking for a lift pad for Resident #120 and UM #1 instructed her to contact the Lead NA to obtain the lifting pad. UM #1 stated the next time on 7/18/18 she observed Resident #120 was in the dining room for breakfast. Interview on 09/20/18 at 4:36 PM with Nurse #2	F 689	This plan of correction constitutes a written allegation of compliance, preparation, and submission of the plan of correction does not constitute admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of requirement under state and federal law. Corrective Action for those residents that have not been affected. On 7/18/18 it was observed that resident #120 had a swollen knee. Upon notification to DON, resident was sent to the hospital after a positive x-ray for fracture was concluded. A 24-Hour report was initiated and an investigation began to drill down to the root cause. Upon interview of the aid that provided care on the day shift 7/18/18 it was discovered that she did not transfer the resident correctly. This aide was in-serviced and disciplinary action was taken and documented. Corrective action will be accomplished for those residents to be affected by the same deficient practice. All residents that have limited mobility of lower extremities that require a Hoyer lift have had a full body assessment to	

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F 689	Continued From page 12 stated around 6:00 PM on 7/18/18 NA #2 informed her that Resident #120 had a skin tear with dried blood and the resident's left leg was swollen, painful, and bruised. Nurse #2 notified the on-call Nurse Practitioner who ordered an x-ray of the left leg. Further interview revealed she administered Acetaminophen extra strength (2) tablets for pain. Interview on 09/20/18 at 1:31 PM with the Administrator and Director of Nurses (DON) was conducted. The Administrator and DON indicated NA #1 was should have used the mechanical lift to transfer Resident #120 into and out of bed. Interview on 09/20/18 at 4:47 PM via phone with NA #1 stated when she arrived on duty (7/18/18 during the 7 AM-3 PM shift) Resident #120 needed to be transferred out of bed for breakfast and she could not find a lifting pad so "I transferred her (Resident #120) out of bed by myself." NA #1 stated "I made a mistake" when she transferred Resident #120 by herself and did not use a lift. Further interview with NA #1 stated she was unware of any skin tears that Resident #120 sustained on 7/18/18. Interview on 9/25/18 at 3:09 PM via phone with the attending physician revealed Resident #120 was fragile, dependent on staff for transfers and had osteoporosis. During the conversation the attending physician stated she was unsure how staff handled her during transfers but that her bones could break at any time with or without associated trauma.	F 689	ensure there are no outstanding injuries. This was completed by the DON, Unit Managers, Unit Coordinators, and Supervisors. This facility houses 17 residents that use a Hoyer lift and have lower leg contractures. All residents have been assessed and no new injuries were discovered. This audit was 100% completed on 7/20/18. Beginning on 7/19/18 all clinical staff were in-serviced by the DON, the supervisor, the Lead CNAs) or a designee on the procedure. The in-service reviewed the care card explanation of how to transfer a resident as well as using the appropriate sling for transferring residents via Hoyer-lift. Of the 101 clinical staff, 100% have been in-serviced. 100% of staff were in-serviced by 8/10/18. Any clinical staff that has not been in-serviced will be in-serviced by their next shift of work. This will be part of the orientation process for all clinical staff. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. The DON, Administrator, Unit Managers, Unit coordinators, supervisor, or their designee will observe certified nursing assistants on the process of transfer of the resident to ensure correct transfers. This will be documented on the audit tool, that contains Staff's name, date observed,	

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F 689	Continued From page 13	F 689	room#, a note section, & observers initial. These observation are done on all shifts as necessary and weekends. Six will observations will be done a week for thirty days, then three observations weekly for thirty days, and then one observation for the next thirty days. The DON or Administrator and/or their designee will review the audit sheets weekly for accuracy and address discrepancies with the appropriate staff. This will begin on 7/20/18. The Facility Plans to Monitor its performance to make sure the solutions are sustained. The Administrator and/or DON will observe audit tool weekly and will present the findings to the Quality Assurance Performance Improvement Committee monthly for three months or until a pattern of compliance is obtained. This will be completed by 10/12/18.	
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	F 761		10/12/18

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F 761	Continued From page 14 §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 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and consultant pharmacist interviews, the facility: 1) Failed to store medications as specified by the manufacturer in 2 of 3 medication carts (Unit 2 Med Cart 2 and Unit 1 Med Cart 2); 2) Failed to remove expired medications from 2 of 2 medication storerooms (Unit 2 Med Room and Unit 1 Med Room); and, 3) Failed to dispose of a loose, unidentified tablet observed at the bottom of a soiled compartment on 1 of 3 medication carts (Unit 2 Med Cart 1). The findings included: 1a) Accompanied by Nurse #4, an observation of the Unit 2 Medication Cart 2 was conducted on 9/19/18 at 9:30 AM. A bottle of 200 units/activation calcitonin nasal spray (a medication indicated for the treatment of postmenopausal osteoporosis) dispensed for Resident #4 was observed to be lying on its side in the top drawer of the medication cart. The	F 761	This plan of correction constitutes a written allegation of compliance, preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal Law. Corrective Action for those residents that have been affected. On 9/19/18 it was observed that calcitonin nasal spray and fluorometholone opthalmic suspension (eye drops) not placed upright in the cart per manufacture guidelines. The nasal spray and	

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F 761	Continued From page 15 manufacturer labeling on the bottle of the calcitonin included instructions to store the bottle in the upright position. After reviewing the medication ' s storage and labeling, Nurse #4 attempted to reposition the bottle and close the top drawer. However, the drawer would not close with the calcitonin bottle standing upright. The nurse stated, "Someone moved it from where it was supposed to be." The nurse was then observed as she placed the calcitonin standing upright in another drawer of the medication cart. A review of Resident #4 ' s Physician Orders revealed there was a current order for 200 units/activation calcitonin nasal spray to be given as one spray into alternating nares once daily. An interview was conducted on 9/20/18 at 7:41 AM with the facility ' s Director of Nursing (DON). During the interview, the observations of medication storage on the med carts was discussed. At that time, the DON stated her expectation for medication storage was to follow the proper procedures based on the individual medications. An interview was conducted on 9/20/18 at 11:04 AM with the facility ' s consultant pharmacist. During the interview, the observations of medication storage on the med carts and med room were discussed. The pharmacist had no questions or disagreements regarding the findings of the medication storage observations. 1b) Accompanied by Nurse #5, an observation of the Unit 1 Medication Cart 2 was conducted on 9/19/18 at 9:50 AM. A 5 milliliter (ml) bottle of 0.1% fluorometholone ophthalmic suspension (a steroid-containing eye drop) dispensed for	F 761	eyedrops were each placed ina seperate container upright in the cart to keep them in an upright posisiton. The consultant pharmacist was notified, and no further recommendation were give. On 9/19/18 It was observed that the Medication refridgerator had an exipred TB skin test. On 9/20/18 the TB skin test was removed and sent back to pharmacy. A new bottle was ordered and arrived at the facilty with the PM pharmacy delivery. On 9/19/18 it was observed in the medication cart that an unidentified pill was at the bottom of the medication cart. This was removed and discarded and the cart was immediately cleaned. Corrective action will be accomplished for those residents to be affected by same deficient practice. On 9/20/18 all medication carts and refridegerators were checked for expired medications, and correct positionsing of medicaitonts required to be upright. No other medications were observed that were expired or needed placed in an upright position, and unidentified medications. On 9/24/18 Education began for the clinical staff regarding medicaition policy and procedure based on manufactureing recommendation for proper storage of medication.	

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F 761	Continued From page 16 Resident #71 was observed to be lying on its side with the other eye drops stored on the medication cart. The storage instructions on the manufacturer labeling of the fluorometholone eye drops was covered by the pharmacy label. The manufacturer recommendations for storage of the fluorometholone ophthalmic suspension indicated the bottle of eye drops should be stored in the upright position. A review of Resident #71 ' s Physician Orders revealed there was a current order for 0.1% fluorometholone ophthalmic suspension to be given as one drop into the right eye twice daily. An interview was conducted on 9/20/18 at 7:41 AM with the facility ' s Director of Nursing (DON). During the interview, the observations of medication storage on the med carts was discussed. At that time, the DON stated her expectation for medication storage was to follow the proper procedures based on the individual medications. An interview was conducted on 9/20/18 at 11:04 AM with the facility ' s consultant pharmacist. During the interview, the observations of medication storage on the med carts and med room were discussed. The pharmacist reported she was made aware of the storage concern for the fluorometholone ophthalmic suspension. She reported the resident ' s insurance would not replace the eye drops at this time. After calling the manufacturer, she reported telling the facility they could use these eye drops for Resident #71, but that the bottle needed to be stored in an upright position. The pharmacist had no questions or disagreements regarding the findings of the medication storage observations.	F 761	On 10/4/18 Education began for clinical staff regarding medicaiton policy and procedure for expired medications and medication cart cleanliness. On10/4/18 of the 35 clinical staff 32 have completed these in-services. By 10/12/18 All staff will complete this in-service. Any staff that have not completed by this date will have it completed prior to their next shift. This will be part of the new nurse orientation process. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. The DON and/or her designee(s) will audit the five medications carts and 4 medication rooms in the facility to ensure the that there are not expired medications and they are stored per manufactures recommendations. This will be done 3 times a week for the next four weeks and then 2 times a week for four weeks, and then 1 time weekly for the next 4 weeks. The audit tool will general appearance, med cart, control drugs, emergency kits, refreidgerator/freezers, nurse auditor, and comments. The facility plans to monitor its performance to make sure solutions	

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F 761	Continued From page 17 2a) An observation of the Unit 2 Medication Room was conducted on 9/19/18 at 4:23 PM. The observation revealed an opened vial of Tuberculin PPD injectable medication (used for skin test in the diagnosis of tuberculosis) was stored in the refrigerator. A hand-written date indicated the Tuberculin PPD medication was opened on 8/15/18. The manufacturer ' s product information indicated opened vials of Tuberculin PPD injectable medication should be discarded after 30 days. An interview was conducted on 9/19/18 at 4:40 PM with the facility ' s Director of Nursing (DON). During the interview, the observations of opened vial of Tuberculin PPD (dated 8/15/18) stored in the med room refrigerator was discussed. Upon inquiry as to how long the Tuberculin PPD could be kept after opened, the DON answered, "30 days." During a follow-up interview conducted on 9/20/18 at 7:41 AM, the DON stated her expectation for medication storage was to follow the proper procedures based on the individual medications. An interview was conducted on 9/20/18 at 11:04 AM with the facility ' s consultant pharmacist. During the interview, the observations of medication storage were discussed, including the expired Tuberculin PPD. The pharmacist had no questions or disagreements regarding the findings of the medication storage observations. 2b) An observation of the Unit 1 Medication Room was conducted on 9/20/18 at 9:47 AM. The observation revealed two opened vials of	F 761	are sustained. The Director of Nursing will present the findings of Medication storage to the Quality Assurance Performance Improvement committee montly for three months or until a pattern of compliance is obtained. This will be competed by 10/12/18.	

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F 761	Continued From page 18	F 761		

Tuberculin PPD injectable medication (used for skin test in the diagnosis of tuberculosis) were stored in the refrigerator. A hand-written date indicated both of the Tuberculin PPD vials were opened on 8/17/18.

The manufacturer ' s product information indicated opened vials of Tuberculin PPD injectable medication should be discarded after 30 days.

An interview had been conducted on 9/19/18 at 4:40 PM with the facility ' s Director of Nursing (DON). During the interview, the observation of an opened vial of Tuberculin PPD (dated 8/15/18) stored in the Unit 2 Med Room refrigerator had been discussed. This interview was conducted prior to the observation of the additional opened, expired Tuberculin PPD vials in the Unit 1 Med Room. Upon inquiry as to how long Tuberculin PPD could be kept after being opened, the DON answered, "30 days." During a follow-up interview conducted on 9/20/18 at 7:41 AM, the DON had stated her expectation for medication storage was to follow the proper procedures based on the individual medications.

An interview was conducted on 9/20/18 at 11:04 AM with the facility ' s consultant pharmacist. During the interview, the observations of medication storage were discussed, including the expired Tuberculin PPD. The pharmacist had no questions or disagreements regarding the findings of the medication storage observations.

3) Accompanied by Nurse #3, an observation of the Unit 2 Medication Cart 1 was conducted on 9/19/18 at 9:12 AM. The observation revealed the bottom of one compartment in top drawer of the

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F 761	Continued From page 19 medication cart contained a yellow, sticky substance. Two stock bottles of medication were stuck to the bottom of the drawer. Removal of the two stock bottles revealed there was one loose, unidentified tablet stuck in the yellow substance at the bottom of the compartment. Upon inquiry, Nurse #3 reported she typically didn't use these two stock meds very often so had not noticed the yellow substance at the bottom of the compartment. The nurse removed the loose, unidentified tablet from the bottom of the compartment and was observed as she discarded it. An interview was conducted on 9/20/18 at 7:41 AM with the facility ' s Director of Nursing (DON). During the interview, the observations of medication storage on the med carts was discussed. At that time, the DON stated her expectation for medication storage was to follow the proper procedures based on the individual medications.	F 761		
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.	F 812		10/12/18

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F 812	Continued From page 20 (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. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain kitchen equipment clean and in a sanitary condition to prevent cross contamination by failing to clean the convection oven, the conventional oven, failed to clean the drink gun nozzle, failed to remove grease build up from 7 of 7 sheet pans, failed to clean the can opener and failed to store pans completely dry. The findings included: During the initial kitchen tour on 9/18/18 at 9:18 AM the kitchen work area was observed. The bottom inside of the convection oven was observed with black charred food particles. The conventional oven door handle was greasy to touch and the bottom inside was observed to have black charred food particles. The drink gun nozzle was observed to have a dark brown residue build up inside the nozzle. 2 of 2 full size hotel pans were observed nested wet and 2 of 3 half size hotel pans were observed stored nested wet. During the meal observation on 9/18/18 at 11:18 AM the conventional oven door handle was greasy to touch and the bottom inside of the oven was observed to have black charred food particles. 7 of 7 sheet pans stacked on the drying rack, were observed to have 1/8 to ¼ inch of black dried food residue one inch wide under the rim.	F 812	This plan of correction constitutes a written allegation of compliance, preparation, and submission of the plan of correction does not constitute admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of requirement under state and federal law. Corrective Action for those residents that have been affected. Between 9/18/18 and 9/20/18 it was observed debris around the dumpster area, the can opener in need of cleaning, the oven appeared to not have been deep cleaned timely, pans with build up with moisture on them, and the juice gun in need of cleaning. All of these items were addressed by the Certified Dietary Manager and the Kitchen Manager on 9-20-18 Corrective action will be accomplished for those residents to be affected by the same deficient practice. Beginning on 9-25-18 the Administrator and Dietary Manager in-serviced the staff	

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F 812	Continued From page 21 During an observation of the kitchen work area on 9/19/18at 3:43 PM the bottom inside of the convection oven was observed with black charred food particles. The conventional oven handle was greasy to touch and the bottom inside of the oven was observed to have black charred food particles. The drink gun nozzle was observed to have a dark brown residue build up inside the nozzle. An observation of the kitchen work area on 9/20/18 at 9:50 AM revealed the convection oven and conventional oven were in the same condition. At 9:54 AM 2 of 2 half size hotel pans were observed stacked together wet and 8 of 8 sheet pans stacked on the drying rack, were observed to have 1/8 to ¼ inch of black dried food residue one inch wide under the rim. The table mounted can opener was observed to have a greasy black residue build up above the blade and the can opener frame had a greasy black buildup of residue. The drink gun nozzle was observed with a dark colored residue build up inside the nozzle. During an interview 9/20/18 at 9:51 AM the Certified Dietary Manager (CDM) stated Wednesday was the regular cleaning day in the kitchen. However due to a call out the scheduled cleaning staff had to fill in for another dietary staff member who had called out. The CDM stated the ovens did not look thoroughly cleaned and stated staff usually cleaned according to the posted cleaning schedules. During an interview on 9/20/18 at 10:15 AM the dietary staff stated that she usually did clean the drink nozzle and can opener but had gotten busy	F 812	on the areas of concern. these in-services explains that staff is to clean the juice gun, ensure pans are free of build up and air dried prior to stacking, can opener, and oven daily. Of the 18 total dietary staff 17 have been in serviced on the procedures for cleaning these items. Any staff that have not completed this in-service will complete before their next shift. These in-services will be part of the orientation process for all dietary staff hired beginning 9/25/18. This will be conducted by the Staff Development Coordinator or her designee. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. The Dietary Manager and/or the Kitchen Manager or their designee will be responsible for ensuring the can opener, juice gun, pans are free of buildup and air dried prior to storage and ovens are cleaned daily. In addition they will ensure they steamer trays are air dried prior to stacking and pans will be free of buildup. These will be documented on the audit tools. It will document the time, item checked, employee was responsible for the item's cleaning, and initials of individual verifying the cleanliness. This will be logged 5 times a week for four weeks, then 3 times a week for four weeks and then 1 time a week for four weeks.	

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HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27588

(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 812	Continued From page 22 and would clean them right away.	F 812	The Dietary Manager and/or the Kitchen Manager or their Designee also ensure the dumpster area is clean after each trash run breakfast, lunch and dinner. This will be documented on the audit tool five times a week for four weeks and 3 times a week for four weeks, and then 1 time a week for four weeks. The Facility Plans to Monitor its performance to make sure the solutions are sustained. The Administrator will observe the Audit tools Weekly and the Dietary Manager will present the findings to the Quality Assurance Performance Improvement Committee monthly for three months or until a pattern of compliance is obtained. This will be completed by 10/12/18.	
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain the area surrounding the dumpster free of debris for 5 of 5 dumpsters observed. The findings included: During an observation of the dumpster area on 9/18/18 at 9:25 AM, 2 disposable gloves were observed in front of dumpster # 1, assorted papers, straws and Styrofoam cup were in front of	F 814	This plan of correction constitutes a written allegation of compliance, preparation, and submission of the plan of correction does not constitute admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of requirement under state and federal law.	10/12/18

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F 814	Continued From page 23 dumpster # 3 and 3 disposable gloves were to the right of dumpster # 5. During an second observation on 9/19/18 at 8:03 AM 4 disposable gloves were in front of dumpster # 1, assorted papers, straws and Styrofoam cup were in front of dumpster # 3 and 3 disposable gloves were to the right of dumpster # 5. A third observation of the dumpster area on 9/20/18 at 8:22 AM 3 disposable gloves and ice cream cup were observed on the ground between dumpster # 1 and dumpster # 2. 3 disposable gloves were observed on the ground in front of dumpster # 4 and 4 disposable gloves were observed to the right of dumpster # 5 with assorted papers strewn about in front and behind the dumpster area. An observation of the dumpster area was conducted with the certified dietary manager (CDM) on 9/20/18 at 9:57 AM revealed the dumpster area to be in the same condition. During an interview on 9/20/18 at 10:00 AM the CDM stated that the maintenance man went out twice a day to pick up the dumpster area. On 9/20/18 at 10:01 AM the maintenance man stated he went out every morning and afternoon to rake around the dumpster area.	F 814	Corrective Action for those residents that have been affected. 9/18/18 and 9/20/18 the Complaint Survey observed debris and trash around the dumpster area. On 9/20/18 these items were removed from the areas surrounding the dumpster and placed in the trash. Corrective action will be accomplished for those residents to be affected by the same deficient practice. Beginning on 9-25-18 the Administrator and Dietary Manager in-serviced the staff as to picking up debris outside of the dumpsters and surrounding during each trash run during the day. Of the 18 total dietary staff,17 have been in serviced. Any staff that have not completed this in-service will complete by their next shift. This will be done by either the Administrator, Certified Dietary Manager, or the Kitchen Manager. This in-services will be part of the orientation process for all dietary staff hired beginning 9/25/18. The Eductation will be conducted by the Staff Development Coordinator. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. The Dietary Manager and/or the Kitchen Manager or their designee will be responsible for ensuring the dumpster area is free of debris.	

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F 814	Continued From page 24	F 814	The Dietary Manager and/or the Kitchen Manager or their Designee will ensure the dumpster area is clean after each trash run breakfast, lunch and dinner. This will be documented on the audit tool 5 times a week for four weeks and 3 times a week for four weeks, and then 1 time a week for four weeks. The Facility Plans to Monitor its performance to make sure the solutions are sustained. The Administrator will observe the Audit tools Weekly and the Dietary Manager will present the findings to the Quality Assurance Performance Improvement Committee monthly for three months or until a pattern of compliance is obtained. This will be competed by 10/12/18.	
F 880 SS=E	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		10/12/18

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F 880	Continued From page 25 §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 26 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 observations, staff interviews, and record review, the facility staff failed to store residents ' glucometers (device used to measure a resident's blood glucose or blood sugar level) in a manner to prevent potential cross-contamination from contact with other glucometers on 3 of 3 medication carts observed (Unit 2 Med Cart 1, Unit 2 Med Cart 2 and the Unit 1 Med Cart 2). The findings included: A review of the facility policies entitled "Obtaining a Fingerstick Glucose Level" (revised December 2011) read, in part: "18. Clean and disinfect reusable equipment between uses according to the manufacturer ' s instructions and current infection control standards of practice." The storage of the residents ' individual glucometers in a manner to prevent potential cross-contamination from contact with other glucometers was not specifically addressed in the facility policy/procedures. A review of the manufacturer ' s labeling on the wipes (towelettes) used to clean and disinfect	F 880	This plan of correction constitutes a written allegation of compliance, preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal Law. Corrective Action for those residents that have been affected. On 9/20/18 It was observed that the glucometers were not stored separately in the medication cart. On 9/20/18 glucometers were separated by placing one in a plastic bag with a residents name on each bag to identify each resident. In addition the residents name was placed on each glucometer.	

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F 880	Continued From page 27 glucometers at the facility was conducted. The "Cleaning Instructions" read as follows: "Use one [Brand Name] towelette to completely preclean surface of all gross debris. For use as a virucide (an agent active against virus infections), including HIV-1 (human immunodeficiency virus type 1), HBV (hepatitis B virus) and HCV (hepatitis C virus) applications and effectiveness against Methicillin Resistant Staphylococcus aureus (a bacteria which is also known as MRSA), Vancomycin (an antibiotic) Resistant Enterococcus faecalis (a type of bacteria also known as VRE) and Staphylococcus aureus with Reduced Susceptibility to Vancomycin (a type of bacteria): Use a second [Brand Name] towelette to thoroughly wet the surface. Repeated use of the product may be required to ensure that the surface remains visibly wet for 2 minutes at room temperature (68o Fahrenheit / 20o Celsius)." A continuous observation was conducted on 9/19/18 at 8:15 AM as Nurse #3 checked a resident ' s blood glucose using an individual glucometer labeled with the resident ' s name. After the blood glucose check was completed, the nurse wiped the glucometer with one disinfectant wipe for 30 seconds. Nurse #3 was observed as she placed the glucometer in the medication cart (Unit 2 Med Cart 1) with 9 other meters (each labeled for an individual resident). The glucometers were in contact with one another. There was no barrier in place that separated the meters to prevent potential cross-contamination. An observation was conducted of the Unit 2 Med Cart 2 on 9/19/18 at 9:30 AM with Nurse #4. Seven glucometers (each individually labeled with a resident ' s name) were stored on the medication cart. The glucometers were stored on	F 880	Corrective action will be accomplished for those residents to be affected by same deficient practice. On 8/21/18 the DON, Staff Development Coordinator or their designee(s) began education of all Nurses on procedure for glucometer storage and cleaning. This education explains the importance of storing each glucometer separately to avoid any infections control potential. In addition the cleaning of glucometers explained the cleaning and disinfecting procedures using a cavi-wipe to for pre and post procedure, stating the surface of the glucometer must be visibly wet for 2 minutes at room temperature. On 10/4/18 of the 35 clinical staff 35 have been completed this education. The Staff Development Coordinator, or her designee will have this education will be part of the new nurse orientation. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. The DON and her designee(s) will audit the medications carts for glucometer storage (each stored separately in a bag) and cleaning of the glucometers between each use; five times a week for four weeks, the next four weeks the carts will be audited three times a week, and then one time weekly for the next four weeks.	

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F 880	Continued From page 28 the med cart in contact with one another. There was no barrier in place that separated the meters to prevent potential cross-contamination. An observation was conducted of the Unit 1 Med Cart 2 on 9/19/18 at 9:50 AM with Nurse #5. Six glucometers (each individually labeled with a resident ' s name) were stored on the medication cart. The glucometers were stored on the med cart in contact with one another. There was no barrier in place that separated the meters to prevent potential cross-contamination. An interview was conducted on 9/20/18 at 1:12 PM with the facility ' s Infection Control Nurse. Upon inquiry, the nurse stated the residents ' glucometers originally came in a pink bag, but the pink bags had disappeared over time and were no longer used to separate the glucometers. An interview was conducted with the facility ' s Director of Nursing (DON) on 9/20/18 at 2:46 PM in regards to the storage of the residents ' individual glucometers on the med carts. Additionally, the observation of staff failing to clean an individual glucometer as directed by the manufacturer of the disinfectant wipes used and the related concern regarding potential cross-contamination of the glucometers was discussed. When the DON was asked if she had been aware the individual resident glucometers were stored in contact with one another, she stated she did not realize this would be a concern. Upon further discussion, the DON reported she would expect a barrier to be used for storing the individual residents ' glucometers so they would be not be in contact with one another due to the concern for potential cross-contamination.	F 880	The audit tool will contain date, cart, storage correctly, comments, the auditors name, and auditors initials. The facility plans to monitor its performance to make sure solutions are sustained. The Director of Nursing will present the findings of glucometer storage to the Quality Assurance Performance Improvement committee monthly for three months or until a pattern of compliance is obtained. This will be completed by 10/12/18.	

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