STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345264	A. BUILDING ______ B. WING ______	C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEY TOTAL LIVING CENTER	**514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164**

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/21/24 through 10/25/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 39NK11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 10/21/24 through 10/24/24. Additional information was obtained offsite on 10/25/24. Therefore, the exit date was changed to 10/25/24. Event ID #39NK11. The following intakes were investigated: NC00213403, NC00214998, NC00217022, NC00217534, NC00219919, NC00215814, NC00213802, NC00221580, NC00221243, NC00221722, and NC00217514. 2 of 20 complaint allegations resulted in a deficiency. Immediate Jeopardy was identified at: CFR 483.35 at tag F726 at a scope and severity of J. CFR 483.80 at tag F880 at a scope and severity of J. Immediate Jeopardy began on 10/23/24 and was removed on 10/25/24. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity G. Non-noncompliance began on 05/28/24. The facility came back in compliance effective 07/12/24.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		12/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 11/12/2024

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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Continued From page 1

§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.

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F 655	Continued From page 2	F 655		

(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews, the facility failed to develop a baseline care plan that addressed a resident's anticoagulant (blood thinner) medications for 1 of 3 resident reviewed for anticoagulant therapy (Resident #45).

Resident #45 was admitted to the facility on 10/1/24 with diagnosis that included fracture of unspecified part of neck of right femur.

Resident #45's care plan dated 10/1/24 did not include goals and interventions for the use of anticoagulant therapy.

Record review revealed Resident #45 had an admission order for Enoxaparin Sodium Injection 40 milligram subcutaneously one time a day due to right hip fracture until 10/22/24.

An admission Minimum Data Set (MDS) dated 10/7/24 indicated Resident #45 was cognitively intact.

A Review of Resident #45's Medication Administration Record (MAR) for October 2024 revealed Resident #45 received Enoxaparin Sodium injection 40mg/0.4 ml daily from 10/2/24 through 10/22/24.

During an interview on 10/23/24 at 11:40am the MDS Nurse stated she received new orders daily and updated the care plan as needed. MDS

Resident #45 discharged home from the facility on 10/28/24 as scheduled following short-term rehabilitation.

The Director of Nursing conducted an audit on 11/11/24 of all current residents admitted within the last 21 days who have not yet had a comprehensive care plan developed and are currently receiving an anticoagulant. Any baseline care plan missing the anticoagulant use was updated/revised by the MDS Coordinator at that time.

The Director of Nursing revised the Resident Assessment & Care Planning policy and procedure to include the use of an anticoagulant on the baseline care plan for every newly admitted resident on 11/11/24. The Director of Nursing provided education on this revised policy and procedure to the MDS Coordinators on 11/11/24.

To ensure compliance, the Staff Development Coordinator will conduct an audit of each newly admitted resident receiving an anticoagulant to ensure this information has been included on the baseline care plan weekly X 4 weeks beginning on 11/18/24 and ending on 12/15/24--concerns during any of these

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345264	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 10/25/2024
NAME OF PROVIDER OR SUPPLIER: STANLEY TOTAL LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 514 OLD MOUNT HOLLY ROAD, STANLEY, NC 28164	

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F 655	Continued From page 3 Nurse stated the nurses would have to look at the care plan to see anticoagulant therapy goals and interventions and it was also located on the Kardex. The MDS nurse stated she normally entered anticoagulant therapy to the care plan under skin to monitor for abnormal bruising. During an interview on 10/23/24 at 12:13pm the NP stated residents on anticoagulants should be monitored for hematuria and bleeding in addition to bruising. NP stated labs would be done admission then up to NP for further follow up lab work. During an interview on 10/24/24 at 11:42am Nurse #2 stated residents that received blood thinners were monitored for bruising, signs of bleeding, skin color, and blood work would be monitored. Nurse #2 did not know if it was included in the resident's care plan. During an interview on 10/23/24 1:54pm the Director of Nursing (DON) stated nurses should know the risk of anticoagulants and monitor for increased signs of bleeding, bruising, blood in urine. DON stated that care plans were completed by the MDS nurse and anticoagulants were normally added under skin unless specifically care planned. During an interview on 10/24/24 at 3:44pm the Administrator stated nurses should know what to monitor for when a resident is on anticoagulant therapy. The Administrator was not aware that anticoagulant therapy was not in the care plan for reviewed residents. The Administrator stated she didn't know that a specific care plan was required for anticoagulant therapy since nurses should know what to monitor.	F 655	audits will be addressed by the Staff Development Coordinator immediately, including disciplinary action as necessary. To maintain continued compliance, the Staff Development Coordinator will conduct an audit of each newly admitted resident receiving an anticoagulant to ensure this information has been included on the baseline care plan monthly X 3 months followed by quarterly x 3. Findings and results from audits will be reported to the QA&A Committee by the Staff Development Coordinator for any further considerations.	

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		12/15/24

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F 656	Continued From page 5 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to develop and implement a person-centered care plan for residents on anticoagulants for 2 of 3 residents reviewed for development and implementation of a comprehensive care plan (Resident #19 and Resident #34). Findings included: 1) Resident #19 was admitted to the facility on 8/30/24 and re-admitted on 10/2/24 with diagnosis that included right hip fracture from recent fall, Open Reduction Internal Fixation (ORIF) right hip. Record review revealed Resident #19 had an admission order dated 10/2/24 for Enoxaparin Sodium (blood thinner) injection 40mg/0.4 ml subcutaneously one time a day for post-surgery for 21 days. Resident #19's care plan dated 10/3/24 did not include goals and interventions for the use of anticoagulant therapy (received blood thinner medication). A review of Resident #19's Medication Administration Record (MAR) for October 2024 revealed Resident #19 received Enoxaparin	F 656	A person-centered comprehensive care plan for the use of an anticoagulant was developed and implemented for resident #19 on 10/31/24 and resident #34 on 11/11/24 by the MDS Coordinator. The Director of Nursing conducted an audit of all residents currently receiving an anticoagulant to ensure a comprehensive person-centered care plan for the use of an anticoagulant was also in place on 11/11/24. Any resident who did not have a comprehensive person-centered care plan in place for the use of anticoagulant use noted during this audit had one developed and implemented by the MDS Coordinator on 11/11/24. The Director of Nursing revised the Resident Assessment & Care Planning policy and procedure to include the development of a care plan for every resident receiving anticoagulant therapy on 11/11/24. The Director of Nursing provided education on this revised policy and procedure to the MDS Coordinators on 11/11/24. To ensure compliance, the Staff Development Coordinator will conduct an	

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F 656	Continued From page 6 Sodium injection 40mg/0.4 ml daily from 10/3/24 through 10/23/24. Record review revealed a progress note by NP dated 10/9/24 that read Resident #19 had a history of Gastrointestinal (GI) bleed. During an interview on 10/23/24 at 11:40am the MDS Nurse stated she received new orders daily and updated the care plan as needed. MDS Nurse stated the nurses would have to look at the care plan to see anticoagulant therapy goals and interventions and it was also located on the Kardex. The MDS nurse stated she normally entered anticoagulant therapy to the care plan under skin to monitor for abnormal bruising. During an interview on 10/23/24 at 12:13pm the NP stated residents on anticoagulants should be monitored for hematuria and bleeding in addition to bruising. NP stated labs would be done admission then up to NP for follow up lab work. During an interview on 10/24/24 at 11:42am Nurse #2 stated residents that received blood thinners were monitored for bruising, signs of bleeding, skin color, and blood work would be monitored. Nurse #2 did not know if it was included in the resident's care plan. Nurse #2 stated if a resident had a history of GI bleed, then the resident's bowel movements would be monitored closely for signs blood. During an interview on 10/23/24 1:54pm the Director of Nursing (DON) stated nurses should know the risk of anticoagulants and monitor for increased signs of bleeding, bruising, blood in urine. DON stated that care plans were completed by the MDS nurse and anticoagulants	F 656	audit of each current resident receiving an anticoagulant to ensure a comprehensive care plan has been developed for such use weekly X 4 weeks beginning on 11/18/24 and ending on 12/15/24--concerns during any of these audits will be addressed by the Staff Development Coordinator immediately, including disciplinary action as necessary. To maintain continued compliance, the Staff Development Coordinator will conduct an audit of each newly admitted resident receiving an anticoagulant to ensure this information has been included on the baseline care plan monthly X 3 months followed by quarterly x 3. Findings and results from audits will be reported to the QA&A Committee by the Staff Development Coordinator for any further considerations.	

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were normally added under skin unless specifically care planned.

During an interview on 10/24/24 at 3:44pm the Administrator stated nurses should know what to monitor for when a resident is on anticoagulant therapy. The Administrator was not aware that anticoagulant therapy was not in the care plan for reviewed residents. The Administrator stated she didn't know that a specific care plan was required for anticoagulant therapy since nurses should know what to monitor.

2) Resident #34 was admitted to the facility on 3/14/2023 with diagnosis that included paroxysmal atrial fibrillation.

Record review revealed Resident #34 had an active order dated 6/3/24 for Apixaban (blood thinner) give 1 tablet orally two times a day.

Resident #34's care plan dated 6/11/24 did not include goals and interventions for the use of anticoagulant therapy.

A quarterly Minimum Data Set (MDS) dated 9/2/24 indicated Resident #34 was cognitively intact and recieved an anticoagulant during the assesment reference period.

A Review of Resident #34's Medication Administration Record (MAR) Apixaban 5mg was administered twice daily 6/3/24 through 10/23/24.

During an interview on 10/23/24 at 11:40am the MDS Nurse stated she received new orders daily and updated the care plan as needed. MDS Nurse stated the nurses would have to look at the care plan to see anticoagulant therapy goals and

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F 656	Continued From page 8 interventions and it was also located on the Kardex. The MDS nurse stated she normally entered anticoagulant therapy to the care plan under skin to monitor for abnormal bruising. During an interview on 10/23/24 at 12:13pm the NP stated residents on anticoagulants should be monitored for hematuria and bleeding in addition to bruising. NP stated labs would be done admission then up to NP for further follow up lab work. During an interview on 10/24/24 at 11:42am Nurse #2 stated residents that received blood thinners were monitored for bruising, signs of bleeding, skin color, and blood work would be monitored. Nurse #2 did not know if it was included in the resident's care plan. During an interview on 10/23/24 1:54pm the Director of Nursing (DON) stated nurses should know the risk of anticoagulants and monitor for increased signs of bleeding, bruising, blood in urine. DON stated that care plans were completed by the MDS nurse and anticoagulants were normally added under skin unless specifically care planned. During an interview on 10/24/24 at 3:44pm the Administrator stated nurses should know what to monitor for when a resident is on anticoagulant therapy. The Administrator was not aware that anticoagulant therapy was not in the care plan for reviewed residents. The Administrator stated she didn't know that a specific care plan was required for anticoagulant therapy since nurses should know what to monitor.	F 656		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices	F 689		

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F 689	Continued From page 9 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 accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to provide care in a safe manner, which resulted in the resident falling from her bed, striking her head on the corner of the bedside table, which resulted in a laceration to her scalp which required 5 sutures. This was for 1 of 3 residents reviewed for the prevention of accidents (Resident #139). The findings included: A review of Resident #139's quarterly Minimum Data Set assessment dated 04/01/24 revealed severely impaired cognition with no delusions, behaviors, rejection of care, or instances of wandering. Resident #139 was coded as requiring total assistance with bed mobility and transfers. She was also dependent on staff for upper and lower body dressing. Resident #139 was always incontinent of bowel and bladder and was coded as not having had a fall since her last assessment. A review of Resident #139's care plan last updated on 07/03/24 revealed a care plan area for "Falls: At risk for falls due to impaired safety awareness, poor balance, and psychotropic	F 689	Past noncompliance: no plan of correction required.	

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medication use that was initiated on 01/08/23. Interventions included to keep the bed in low position when not performing care for safety and to place a fall mat to the left side of the bed for safety.

A review of facility provided incident and accident logs revealed Resident #139 had an unwitnessed fall on 05/28/24. Per the incident/accident report and analysis, Nurse Aide (NA) #4 reported to Nurse #4 that she had found Resident #139 on the floor of her room. NA #4 stated she was walking by Resident #139's room when she heard "a noise" and went into the room to investigate where she found Resident #139 face down on the floor. Nurse #4 reported Resident #139 was observed lying face down with blood around her head. Nurse #4 surmised that Resident #139 hit her head on the corner of her bedside table which resulted in the injury to Resident #139's head. Nurse #4 reported in the incident report that Resident #139's bed was in a high position and that there was a fall mat in the room but not on the floor by the bed.

Review of the facility's investigation into Resident #139's fall, dated 05/28/24 revealed the facility determined that NA #3, who was assigned to Resident #139 at the time she fell, failed to implement Resident #139's care plan interventions for fall prevention that included a fall mat to her bedside and to keep her bed in a low position.

During an interview with NA #3 on 10/24/24 at 9:21 AM, she verified she was assigned to Resident #139 on 05/28/24 and remembered the fall. She reported she was new to the facility and had just been released from training. She

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F 689	Continued From page 11 continued, stating she was unaware that Resident #139 was a fall risk and reported she did not see a fall mat in Resident #139's room. NA #3 reported she had initially entered Resident #139's room to get her up and ready for the dinner meal. She insisted that she did not touch Resident #139's bed or remove the fall mat. NA #3 stated once she got Resident #139 ready for the dinner meal, she left Resident #139 in the bed to go find another nurse aide or nurse to help her transfer Resident #139 from the bed to her wheelchair. NA #3 stated when she returned with Nurse #6, she saw Resident #139 in the floor and called for help. She insisted that there were no other staff members in the room when she found Resident #139 in the floor, the bed was in a high position, and there was no fall mat in the room. A review of Resident #139's hospital records dated 05/28/24, revealed Resident #139 was seen in the emergency room after suffering a fall at the facility. Per the records, Resident #139 was treated for a laceration on her forehead that was cleaned and sealed with 5 sutures and released back to the facility. An interview with NA #4 on 10/24/24 at 9:46 AM revealed she remembered Resident #139 and the fall she suffered on 05/28/24. NA #4 reported Resident #139 was confused and needed total assistance with 2 people assisting for transfers. She stated on 05/28/24 NA #3 was assigned to Resident #139 but that she and other nurse aides would assist if needed. She stated before the dinner meal, she had taken some trash out of the building and put it in the dumpster and when she returned into the building, as she walked past Resident #139 room, she heard a noise that she described as a "moan" come from Resident	F 689		

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#139's room. She stated she immediately went into Resident #139's room and noted Resident #139 was lying face down in the floor with "a pool of blood" around her. NA #4 stated she called for help and that Nurse #4 came to assist. She reported NA #5 came running to the room as well. NA #4 indicated that Nurse #4 assessed Resident #139 and then she and NA #5 assisted in putting Resident #139 back into her bed until Emergency Medical Services (EMS) arrived to take Resident #139 to the hospital for evaluation and treatment. NA #4 stated while she assisted Resident #139, she noted that her bed was so high that even with the mechanical lift elevated to its highest point, she still had to lower her bed to safely get her back into bed. NA #4 stated she did not see NA #3 until after Nurse #4 had assessed Resident #139 and she and NA #5 were putting Resident #139 back into bed.

An interview with NA #5 on 10/24/24 at 11:03 AM revealed she remembered Resident #139's fall on 05/28/24. She stated she assisted Resident #139 back into her bed after the fall. She reported that Resident #139's bed was in a high position and that her fall mat was leaning against the wall in her room.

An interview with Nurse #4 on 10/23/24 at 2:02 PM revealed she remembered the incident and Resident #139. She reported she was assigned to Resident #139 as her nurse on 05/28/24 and that Resident #139 was confused and totally dependent on others for transfers. She verified that NA #3 was assigned to Resident #139 on 05/28/24 and that she was in another resident's room with Nurse #5 providing care when she was alerted that Resident #139 was in the floor and injured by NA #4. Nurse #4 stated she

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F 689	Continued From page 13 immediately left the resident in the care of Nurse #5 and went to attend to Resident #139. She stated when she entered the room, she observed Resident #139 lying face down with blood around her head. She stated she went to Resident #139 and assessed her and placed a towel to a laceration on Resident #139's head. She stated after she assessed Resident #139 and had NA #4 and NA #5 assist Resident #139 back into her bed until EMS could arrive. Nurse #4 stated she was aware Resident #139 was a fall risk and she did not know why her bed was in a high position and her fall mat was not by her bedside with no one in the room. She reported she did not see NA #3 until after Resident #139 was back into bed and NA #3 reported to her that she had left Resident #139 to get assistance in transferring her from her bed to her wheelchair for dinner. An interview with Nurse #6 on 10/21/24 at 10:18 AM revealed she had no interaction with Resident #139's fall. She stated she did observe the aftermath and that before the fall occurred she observed NA #3 walk by her while she was charting at the 100 hall's nurses station. Nurse #6 reported about 5-10 minutes later, NA #3 walked back past the nurses station and looked confused. At that time, Nurse #6 reportedly asked NA #3 if she needed help and NA #3 responded she was looking for someone to help her transfer Resident #139. Nurse #6 stated she thought it was odd that NA #3 was all the way on the other side of the facility from where Resident #139 was located looking for someone to assist her when Nurse #6 knew there were at least 2 nurses and several other nurse aides assigned to the unit where Resident #139 was located. Nurse #6 reportedly told NA #3 she would be happy to assist her and walked with NA #3 back to	F 689		

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Resident #139's room. She stated when they arrived at the room, she observed Nurse #4 and 2 nurse aides in the room attending to Resident #139 who was face down on the floor.

During an interview with the Director of Nursing on 10/24/24 at 1:53 PM, she reported she remembered Resident #139 and stated she was a confused resident who was a fall risk due to poor safety awareness but had not been identified as a frequent faller. She reported Resident #139 had a fall prevention care plan in place on 05/28/24 and that the interventions included to keep her bed in a low position while she was in bed and to place a fall mat to the left side of her bed. The Director of Nursing stated when Resident #139 fell on 05/28/24 and the facility completed the investigation, it was determined that NA #3 had not followed Resident #139's care plan for fall prevention and was terminated. The Director of Nursing reported when she questioned NA #3, she informed her that she had left Resident #139 to go find someone to assist with transferring Resident #139 from the bed. She stated NA #3 had been thoroughly educated and should have been familiar with Resident #139 and her care needs. She indicated if NA #3 had to go find someone to assist her with transferring a resident, she should have lowered the bed to a low position and replaced the floor mat. She stated after the fall, the facility provided education to all of the staff, completed audits, and placed the fall into the facility quality assurance program.

During an interview with the Administrator on 10/24/24 at 2:01 PM, she stated she was aware of the incident and that it was determined that NA #3 had not implemented and followed Resident #139's fall prevention care plan, which resulted in

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Resident #139 falling and injuring herself and was sent out to the hospital for treatment. The Administrator stated she was made aware of the fall when Nurse #4 called her and told her Resident #139 had fallen and injured herself. She stated during this telephone call, Nurse #4 also reported concerns as to the way she found the room when she attended to Resident #139. The Administrator reported Nurse #4 informed her that Resident #139's bed was in a high position and that her fall mat was leaning up against the wall. The Administrator stated she immediately suspended NA #3 and had her go home and began her investigation. She stated when she interviewed NA #3, NA #3 reported she did not know Resident #139 was a fall risk and was unaware of any fall interventions that were in place. When the Administrator questioned why she was not looking at the fall risk binder located at the nurses station NA #3 reportedly told her that she was never informed of the binder. The Administrator stated she reviewed NA #3's training and determined she had signed off on being trained about the location of the fall risk binder. The Administrator revealed she ultimately terminated NA #3 from the facility. She stated she placed the fall into the facility's quality assurance program, reeducated all the staff on fall prevention and care plans, and completed audits on the residents in the facility. She reported she expected her staff to be aware of all care plans and interventions or how to find them and to implement the interventions to keep the residents safe.

The facility provided the following corrective action plan with a compliance date of 07/12/24:

Address how corrective actions will be

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accomplished for those residents who have been affected by the deficient practice:

Upon finding Resident #139 lying on the floor of her room on 5/28/24 at 5:15pm, she was sent to the hospital for immediate medical care by the licensed nurse on duty.

Due to concerns for failure to follow the written care plan for resident fall safety noted by the licensed nurse on duty at the time of the fall, the CNA (NA #3) responsible for the provision of care for Resident #139 on 5/28/24 from 7am - 7pm was placed on suspension at 5:52pm pending further investigation by the Administrator.

Address how the facility identified other residents having the potential to be affected by the same deficient practice:

On 5/28/24 between 5:52pm - 6:15pm, the licensed nurse on duty assigned nursing assistants to conduct safety rounds on all residents assigned to the same CNA responsible for providing care to Resident #139 (NA #3) to determine if there were any other residents affected by the deficient practice of this specific nursing assistant to address any immediate safety concerns. During these rounds, three residents specifically were found in bed with the bed in the highest position, putting them at risk of falling out of bed with injury. Assigned nursing assistants provided the necessary care to each of these residents immediately, including getting them up for dinner and placing all beds in the lower position for safety.

On 5/28/24 between 6:00pm - 6:30pm, the licensed nurses on the unit conducted rounds on

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all other residents as well to ensure there were no other concerns or residents affected by deficient practice-there were no other concerns for resident safety with all devices in place as ordered and beds in the lowest position at that time.

Address what measures were put in place or what systemic changes were made to ensure that the deficient practice will not recur:

Based on the findings of the facility investigation by the Administrator, the CNA (NA #3) was terminated on 6/3/24 for failure to follow the safety care plan as written for Resident #139.

Between 5/29/24 - 6/3/24, the Staff Development Coordinator provided re-education to all nursing staff on their responsibility to ensure that all safety rounds are completed and all nursing interventions are in place for all residents assigned to them at all times including fall mats and the appropriate position of the bed for each particular resident. Staff who did not attend one of the training sessions after 6/3/24 due to vacation, PRN status, or FMLA were not allowed to work until this training was completed. This training is included in new hire orientation and will also be completed at least annually for all nursing staff.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

Based on findings of the investigation, the Administrator assigned audits to be conducted daily x 8 days on each unit for both day and evening shifts by the Director of Nursing,

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Assistant Director of Nursing, and Infection Control Preventionist to ensure all safety interventions currently ordered were in place for all residents as well as education for nursing staff on duty of the importance of making safety rounds during their shift with successful demonstration on where to locate resident care plans including safety devices ordered due to fall risk. There were no concerns noted during each audit conducted.

Following the completion of daily audits x 8 days, the Administrator assigned audits to be conducted weekly by the Director of Nursing, Assistant Director of Nursing, and Staff Development Coordinator x 6 weeks between 6/4/24 - 7/12/24 to ensure all safety interventions currently ordered were in place for all residents as well as education for nursing staff on duty of the importance of making safety rounds during their shift with successful demonstration on where to locate resident care plans including safety devices ordered due to fall risk. There were no concerns noted during each audit conducted. The Director of Nursing, Assistant Director of Nursing, and Staff Development Coordinator decided on 07/12/24 to take the plan to the next QAPI Committee meeting scheduled for 7/19/24 for further review and continue to monitor for compliance.

Date of Compliance: 7/12/24

The corrective action plan was validated on 10/24/24. Review of the facility provided monitoring tools revealed the facility had ongoing monitoring to ensure fall care plan interventions including keeping beds in low position and fall mats in place while residents were in bed were in

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F 689	Continued From page 19 place. Observations made of residents with fall interventions revealed care plan interventions to be in place. There was evidence of in-services with sign-in sheets, audits, and other interventions that were mentioned in the corrective action plan. Interviews with staff revealed they were able to verbalize the education regarding fall interventions and procedures, notification of a fall, and what to do if they notice a fall intervention not in place. The completion date of 07/12/24 was validated.	F 689		
F 726 SS=J	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 §483.71. §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.	F 726		12/15/24

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§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 observations, record review and staff interviews, the facility failed to verify and demonstrate competency for cleaning and disinfecting a shared glucometer according to the manufacturers' recommendations for using an Environmental Protection Agency (EPA) approved disinfectant cloth for 1 of 4 nursing staff reviewed for competent nurse staff. Nurse #1 was observed not disinfecting a shared glucometer after use on Resident #28 and before use on Resident #7. Failure to use an approved product and procedure to disinfect a glucometer in accordance with the manufacturer's instructions has the high likelihood to expose residents to bloodborne pathogens.

Immediate jeopardy began on 10/23/24 when Nurse #1 failed to demonstrate competency in disinfecting a shared glucometer between residents. Immediate jeopardy was removed on 10/25/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training.

Findings included:

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The blood glucose meter used by Nurse #1 was properly cleaned and disinfected by the Director of Nursing once she became aware of the initial concern on 10/23/24. Residents #7 and #28 were not negatively affected by the deficient practice of Nurse#1.

All resident clinical records were reviewed by the Director Of Nursing on 10/23/24 in which there were no residents with any active diagnosis of any type of bloodborne pathogen that would cause concern related to the failure to properly clean a shared glucose meter before and after use between residents. Nurse #1 was terminated from employment on 10/23/24 to ensure no other residents had the potential of being affected by her potential for continued deficient practice.

The Diabetes Management Policy and Procedure was updated by the Director Of Nursing on 10/23/24 to include the step-by-step requirements for the appropriate cleaning and disinfecting guidelines of shared glucose meters using the required germicidal disposable wipes.

Between 10/23/24 at 4:30pm and 10/24/24 at 6:00pm, training/education

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This tag is cross referred to:

F 880- Based on observations, record review, staff and Nurse Practitioner interviews, the facility failed to disinfect a shared glucometer between Resident #28 and Resident #7 according to the facility's policy and the manufacturer's user guide. Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-approved disinfectant in accordance with the manufacturer's instructions for disinfection of the glucometer has the high likelihood to expose residents to bloodborne pathogens. None of the current residents were diagnosed with a bloodborne pathogen. This deficient practice affected 1 of 3 residents who required blood glucose levels checks (Resident #7).

Review of Nurse #1's training records revealed the following:

- A sign in sheet dated 1/24/24 with Nurse #1's name present was titled Proper Storage of Diabetic Supplies, walking education, completed by the pharmacy. Literature attached to the sign in sheet was titled: "Proper Storage of Diabetic Supplies" and read in part: Glucometer should be properly cleaned following manufacturer's guidelines. Best practice is for each patient to have their own meter. If using "house meter, proper cleaning must be performed after each use. The in-service did not specify what to use to clean the meter or how to clean the meter.

-A point of care testing observation had been completed for Nurse #1 by the SDC on 5/13/24

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was provided both in person and via Zoom for all licensed nursing staff by the Staff Development Coordinator, Infection Control Preventionist, ADON/Case Management Coordinator, and Director of Nursing on the revised Diabetes Management Policy and Procedure for properly cleaning and disinfecting shared blood glucose meters before and after each use as well as the significance of doing so for the safety/health of every resident related to the high likelihood for the spread of blood borne pathogens which included validation of competency, either in-person or through verbally providing the appropriate steps of the procedure. This training specifically included the brand of disinfectant pad/wipe required, the requirement for the disinfecting of the full surface area of the blood glucose meter itself, and the required length of wet contact time.

Training on the Diabetes Management policy and procedure, including the steps and requirements for properly cleaning and disinfecting shared glucose meters before and after each use will be included in the new hire orientation provided by the Staff Development Coordinator who will be responsible for ensuring this training and competency is completed with all licensed nurses, including any agency staff if used—this training and competency will be completed prior to each licensed nurse starting their first shift with any resident. Following initial orientation, training on the Diabetes Management policy and procedure,

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and 5/15/24. Cleaning/ disinfecting the testing meter was included on the audit form and indicated that Nurse #1 had completed the cleaning/ disinfecting of the meter correctly.

-A form with Nurse #1's name, titled "Nurse's Annual Skills Check" had been completed on 6/2/23 and included glucometer disinfecting.

-Nurse #1's online education module transcript revealed she had completed an online module entitled "Professional Responsibility in Infection Prevention" on 6/9/24. The module content included education on infection transmission and the reduction of the risk of infections associated with medical equipment, devices and supplies.

An interview was conducted with the Staff Development Coordinator (SDC) on 10/23/24 at 12:16 PM. The SDC stated the facility educated nurses on procedures for glucometer disinfection during new hire orientation and annually. She said nurses were educated annually on glucometer disinfection through the facility's skills fair. The SDC stated the facility had held its annual skill fair at the beginning of October. The SDC explained that Nurse #1 had not attended the skills fair in October and still needed to complete her annual skills competency. The SDC said that she had a "make up list" for nurses who had not attended the skills fair and had planned to have them complete the skills fair makeup this week.

An interview with was conducted on 10/23/24 at 7:53 AM with Nurse #1. Nurse #1 said she had worked at the facility for about 3 years. She stated she had received training on disinfecting glucometers but did not recall when exactly she

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including the steps and requirements for properly cleaning and disinfecting shared glucose meters before and after each use will then be provided by the Staff Development Coordinator at least annually via a skills/competency fair for all licensed nurses. Any licensed nurse who does not attend this mandatory annual competency assessment during the scheduled time will not be allowed to work hands on with any resident until this has been completed.

To ensure compliance in following the required steps for properly cleaning and disinfecting shared glucose meters, the Staff Development Coordinator will conduct audits beginning on 11/18/24 of 6 random licensed nurses on both shifts (3 day shift/3 night shift) weekly X 4 weeks, which will include being able to both verbally review the required steps noted in the Diabetes Management Policy as well as successfully completing all required steps through hands-on observation--concerns during any of these audits will be addressed by the STaff Development Coordinator immediately, including disciplinary action up to and including termination for the safety of residents as necessary.

To maintain continued compliance in following the required steps for properly cleaning and disinfecting shared glucose meters, the Staff Development Coordinator will conduct an audit of 6 random licensed nurses on both shifts (3 day shift/3 night shift) monthly X 3 months

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F 726	Continued From page 23 had received the training. Nurse #1 said that she thought alcohol was what she was supposed to use to disinfect the glucometer. She said she could use an alcohol prep pad or could use alcohol-based hand sanitizer. Nurse #1 removed a disinfectant wipe from her medication cart and said the disinfectant wipe could also be used but that it cleaned the glucometer the same as the alcohol would. She could not state the process for disinfecting the glucometer. Nurse #1 did not say why she had not attended the skills fair. A sign in sheet titled "Nurse Annual Skill Check" dated 10/3/24 and 10/4/24 revealed Nurse #1's name was not on the sign in log. An interview was conducted with the Director of Nursing (DON) on 10/23/24 at 12:56 PM. The DON stated nurses should be educated during new hire orientation and annually on glucometer disinfection procedures. The DON said Nurse #1 had received education in the past on glucometer disinfection. The DON said point of testing audits for the glucometer had been completed for Nurse #1 and that Nurse #1 had disinfected the glucometer correctly on the audit. She could not say why Nurse #1 had not known the correct procedure for disinfecting the shared glucometer, except that she might have been nervous. An interview was conducted with the Administrator on 10/23/24 at 1:20 PM. The Administrator stated that education on glucometer disinfection should be completed during new hire orientation and annually for nurses. She said with the amount of education that Nurse #1 had received she did not know why she did not know the procedure for disinfecting the shared glucometer.	F 726	and then on a routine quarterly basis as part of the ongoing QAPI process. These audits will include being able to both verbally review the required steps noted in the Diabetes Management Policy as well as successfully completing all required steps through hands-on observation. Concerns during any of these audits will be addressed by the Staff Development Coordinator immediately, including disciplinary action up to and including termination for the safety of residents. Findings and results from audits will be reported to the QA&A Committee by the Staff Development Coordinator quarterly.	

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The facility's Administrator was informed of the immediate jeopardy on 10/23/24 at 2:52 PM.

The facility submitted an acceptable credible allegation of immediate jeopardy removal.

The following interventions were put into place to remove the immediate jeopardy:

1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

On 10/23/24 at 7:28 am, Nurse #1 failed to properly clean and disinfect one shared blood glucose meter after use for Resident #28 and was then stopped before Resident #7 was tested during a medication pass.

Nurse #1 failed to attend the skills fair that included glucose disinfection training and competency that was offered in October 2024.

Both Resident #7 and Resident #28 were at risk of suffering from the deficient practice. All residents being cared for/medicated by Nurse #1 who required a blood glucose check using the shared glucometer at any time while Nurse #1 was on duty were also at risk from being affected by the deficient practice because Nurse #1 could not verbalize the correct steps to disinfect the glucometer.

(12) other licensed nurses were identified as not having completed the most recent training and competency on disinfecting shared blood glucose meters. These licensed nurses received education/competency by the Staff Development

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Coordinator, Infection Control Preventionist, ADON/Case Management Coordinator, and DON on the Diabetes Management Policy and Procedures for properly cleaning and disinfecting shared blood glucose meters before and after each use as well as the significance of doing so for the safety/health of every resident related to the high likelihood for the spread of blood borne pathogens between 10/23/24 at 4:30 pm and 10/24/24 at 6:00 pm. Any of these licensed nurses who failed to complete this training within this time frame will not be allowed to work prior to receiving this education.

Nurse #1 was terminated from employment on 10/23/24 at 4:00 pm to ensure no other residents on her assigned unit have the potential of being affected by continued deficient practice.

2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

Between 10/23/24 at 4:30 pm and 10/24/24 at 6:00 pm, training/education was provided both in person and via Zoom meeting for all licensed nursing staff by the Staff Development Coordinator, Infection Control Preventionist, ADON/Case Management Coordinator, and DON on the Diabetes Management Policy and Procedures for properly cleaning and disinfecting shared blood glucose meters before and after each use as well as the significance of doing so for the safety/health of every resident related to the high likelihood for the spread of blood borne pathogens which included validation of competency, either in-person or through verbally

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F 726	Continued From page 26 providing the appropriate steps of the procedure. This training specifically included the brand of disinfectant required, the requirement for the disinfecting of the full surface area of the blood glucose meter itself, and the required length of wet contact time. No current licensed nurse will be allowed to work prior to receiving this education from the Staff Development Coordinator, Infection Control Preventionist, ADON/Case Management Coordinator, and DON. This training will be included in the new hire orientation provided by the Staff Development Coordinator who will be responsible for ensuring this training and competency is completed with all licensed nurses, including any agency staff if used, during initial orientation and prior to starting their first shift .The education and competency of every licensed nurse regarding the proper cleaning and disinfecting of a multi-use blood glucose meter will be reviewed and verified by the Staff Development Coordinator at least annually via a skills fair any licensed nurse who does not attend this mandatory annual competency assessment during the scheduled time will not be allowed to work until this has been completed. The Administrator and Director of Nursing are responsible for the implementation and completion of the removal plan. The immediate jeopardy was removed on 10/25/24. On 10/24/24 the facility's credible allegation of immediate jeopardy removal was validated by the following: An onsite validation was completed on 10/24/24	F 726		

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F 726	Continued From page 27 at the facility. The validation was evidenced by nurse and administrative interviews conducted that included the required infection control practices for glucometers. Review of the facility Diabetic Management policy revealed the policy had been updated to include additional procedures for glucometer disinfection. Interviews with nurses revealed they had received education on the facility's glucometer disinfection policy/ procedures and completed glucometer disinfection competency validation. Nurses were able to state the correct process for disinfecting the facility's shared glucometers, including the correct product to use and wet contact time of two minutes. Nurses were able to verbalize glucometers needed to be disinfected before/ after each use to prevent the transmission of bloodborne pathogens. Observations were conducted and revealed nurses correctly disinfected the facility's shared glucometers according to the facility's policy/ procedures. Any current staff, agency staff, or new staff who had not received education and competency validation on glucometer disinfection would not be allowed to work by the facility until the education and competency had been completed. The immediate jeopardy removal date of 10/25/24 was validated.	F 726		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758		12/22/24

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(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for

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the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on record review, and interviews with staff and the Nurse Practitioner, the facility failed to limit the duration of a psychotropic medication (medication that may affect brain activities associated with mental processes and behavior) ordered on an as needed (PRN) basis to 14 days for 1 of 3 residents reviewed for unnecessary medications (Resident #19).

Finding included:

Resident #19 was admitted to the facility on 8/30/2024 with diagnosis that included generalized anxiety disorder, unspecified dementia with anxiety, unspecified dementia with mood disturbance.

An admission order dated 8/30/2024 for busPIRone HCl (psychotropic medication) oral tablet 5 milligrams (mg) Give 1 tablet by mouth every 24 hours as needed (PRN) for anxiety. The order had no stop date.

The admission Minimum Data Set (MDS) dated 9/10/2024 indicated Resident #19 was moderately cognitively impaired. The admission MDS indicated Resident #19 was taking an antidepressant, but did not indicate antianxiety medication was being taken.

Review of Resident #19's care plan dated 10/3/2024 revealed Resident #19 had been care planned for psychotropic/antipsychotic medication use. The care plan interventions included:

-Administer psychotropic medications as ordered

F 758

Resident #19's order for Buspar 5mg by mouth every 24 hours as needed for anxiety was reviewed by the Nurse Practitioner on 10/23/24 for appropriate use and orders were rewritten at that time for 14 days and was then discontinued upon the completion of the 14 day period on 11/6/24.

The Director of Nursing conducted an audit of all residents currently receiving PRN psychotropic medications on 11/11/24 to ensure appropriate orders were in place following regulatory requirements with no concerns noted for any other residents.

The pharmacy's Chief Clinical Officer in-serviced the Consultant Pharmacist on the requirement for the duration of PRN psychotropic orders on 10/28/24.

The Admissions & Readmissions policies were both revised by the Director of Nursing on 11/12/24 to include the following details:
(a)the unit nurse completing the initial admission/readmission paperwork including the completion of physician's orders will ensure that any psychotropic medications ordered for PRN use will be limited to 14 days.
(b)within 72 hours of admission or readmission, the Risk Management Coordinator (or designee) will review the admission/readmission physician's orders

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by the physician. Monitor for side effects and effectiveness.

A review of Resident #19's electronic Medication Administration Record (eMAR) for August, September and October 2024 revealed Resident #19 received no busPIRone HCl in August or September of 2024 and one dose on 10/6/2024.

During an interview on 10/23/2024 at 12:13pm the Nurse Practitioner (NP) stated PRN psychotropic/antipsychotic medication orders were to be written for 14 days and then reviewed and rewritten as needed. If a medication was found to be effective after review, the order could be written for a longer, specific number of days. The NP did not know why Resident #19's busPIRone HCL order did not have a 14 day stop date. The NP stated that the resident's admission orders should be reviewed on admission.

During an interview with Nurse #1 on 10/24/2024 10:16am Nurse #1 stated PRN psychotropic orders could only be written for a set number of days, not indefinite.

An interview was completed with Nurse #2 on 10/24/2024 at 11:42am, Nurse #2 stated PRN psychotropic meds could be written for 14 days, then would be reviewed with the NP to see if a new order was needed. Nurse #2 stated when a resident was admitted a medication reconciliation was completed with the NP, if a psychotropic PRN order did not have a stop date the nurse should let NP know and have the order changed to 14 days of duration. Nurse #2 said the busPIRone HCl order for Resident #19 must have been missed during the medication reconciliation.

F 758

to verify that any psychotropic medications ordered for PRN use will be limited to 14 days.

All current licensed nurses and the Nurse Practitioner will receive in-person training by the Staff Development Coordinator by 11/24/24 on the policy revisions and expectations regarding psychotropic medications ordered for PRN use. Training for all licensed nurses on these policies will then be done by the Staff Development Coordinator upon initial orientation and then at least annually.

To ensure compliance in following the policy revisions and expectations regarding psychotropic medications ordered for PRN use, the Assistant Director of Nursing will conduct an audit weekly X 4 weeks for all newly admitted residents to ensure that any psychotropic medications ordered for PRN use will be limited to 14 days. This audit will begin on 11/25/24 and end on 12/22/24. Concerns during any of these audits will be addressed by the Assistant Director of Nursing immediately, including disciplinary action as needed.

To maintain continued compliance upon completion of the weekly audits, the Risk Management Coordinator and the Pharmacy Consultant will each generate a report on a monthly basis to review all residents for the use of psychotropic medications on a PRN basis to ensure use is limited to 14 days. Concerns during any of these audits will be

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F 758	Continued From page 31 During an interview on 10/23/2024 at 1:54pm the Director of Nursing (DON) stated PRN psychotropic/antipsychotic medication orders were to be written for 14 days and then reviewed and rewritten as needed. The DON was not aware Resident #19 had a PRN psychotropic order with no stop date. During an interview on 10/24/2024 at 3:44pm the Administrator stated PRN psychotropic/antipsychotic medication orders were to be written for 14 days and then reviewed and rewritten as needed. The Administrator was not aware Resident #19 had a PRN order for busPIRone HCl with no stop date.	F 758	addressed by the Risk Management Coordinator and/or the Pharmacy Consultant immediately, including disciplinary action as needed.	
F 880 SS=J	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: §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	F 880		12/15/24

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F 880	Continued From page 32 conducted according to §483.71 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 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	F 880		

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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, record review, staff and Nurse Practitioner interviews, the facility failed to disinfect a shared glucometer between Resident #28 and Resident #7 according to the facility's policy and the manufacturer's user guide. Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-approved disinfectant in accordance with the manufacturer's instructions for disinfection of the glucometer has the high likelihood to expose residents to bloodborne pathogens. None of the current residents were diagnosed with a bloodborne pathogen. This deficient practice affected 1 of 3 residents who required blood glucose levels checks (Resident #7).

Immediate jeopardy began on 10/23/24 when Nurse #1 failed to disinfect a shared glucometer between residents. Immediate jeopardy was removed on 10/25/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training.

The findings included:

F 880

The blood glucose meter used by Nurse #1 was properly cleaned and disinfected by the Director of Nursing once she became aware of the initial concern on 10/23/24. Residents #7 and #28 were not negatively affected by the deficient practice of Nurse #1. The MD/Medical Director and Nurse Practitioner were verbally notified of the breach by the Director of Nursing on 10/23/24. The Gaston County Health Department was notified of the breach via email by the Director of Nursing on 10/23/24. The Responsible Party for Resident #28 was notified of the breach by the Direcotr of Nursing on 10/23/24.

All resident clinical records were reviewed by the Director Of Nursing on 10/23/24 in which there were no residents with any active diagnosis of any type of bloodborne pathogen that would cause concern related to the failure to properly clean a shared glucose meter before and after use between residents. Nurse #1 was terminated from employment on 10/23/24 to ensure no other residents had the potential of being affected by her potential for continued deficient practice.

The Diabetes Management Policy and Procedure was updated by the Director Of

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The facility's policy entitled, "Infection Prevention and Control Program" (revised 1/9/23) included: Non-disposable equipment will be cleaned and disinfected after use (glucometers) and "Equipment used by multiple residents will be properly disinfected between the use of each person."

The facility's policy entitled, "Diabetes Management" (Revised 8/7/24) read in part: "Cleaning and Disinfection Guidelines: Glucometers should be cleaned before and after use with a [brand name] disinfect wipe. Use [brand name] disinfect wipe to wipe and thoroughly wet surface area of glucometer thoroughly. Allow surface area to remain wet for two (2) minutes. Let air dry."

The manufacturer's user guide for the glucometer used at the facility included "cleaning and disinfecting guidelines." These instructions noted, in part, "It is policy to advise health care professionals to clean and disinfect meters between each patient test to avoid cross contamination issues." A list of products approved for disinfecting the glucometer was provided by the manufacturer and included the [brand name] disinfectant wipe used by the facility. The manufacturer list of products approved for disinfecting the glucometer did not include alcohol. The manufacturer instructions for using the [brand name] disinfect wipe stated to follow the product label instructions to disinfect the meter.

A [brand name] disinfectant wipe was available for use at the facility to disinfect shared glucometers. The [brand name] disinfect wipe was observed on 10/23/24 at 7:28 AM on the 100

F 880

Nursing on 10/23/24 to include the step-by-step requirements for the appropriate cleaning and disinfecting guidelines of shared glucose meters using the required germicidal disposable wipes.

Between 10/23/24 at 4:30pm and 10/24/24 at 6:00pm, training/education was provided both in person and via Zoom for all licensed nursing staff by the Staff Development Coordinator, Infection Control Preventionist, ADON/Case Management Coordinator, and Director of Nursing on the revised Diabetes Management Policy and Procedure for properly cleaning and disinfecting shared blood glucose meters before and after each use as well as the significance of doing so for the safety/health of every resident related to the high likelihood for the spread of blood borne pathogens which included validation of competency, either in-person or through verbally providing the appropriate steps of the procedure. This training specifically included the brand of disinfectant pad/wipe required, the requirement for the disinfecting of the full surface area of the blood glucose meter itself, and the required length of wet contact time.

Training on the Diabetes Management policy and procedure, including the steps and requirements for properly cleaning and disinfecting shared glucose meters before and after each use will be included in the new hire orientation provided by the Staff Development Coordinator who will be responsible for ensuring this training

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F 880	Continued From page 35 back hall medication cart. The [brand name] disinfectant wipe was a germicidal disinfectant wipe listed as an approved product by the manufacturer of the glucometer for cleaning/disinfecting the facility's [brand name] glucometer. The disinfectant wipe product label listed the product as effective against human immunodeficiency virus (HIV-1), hepatitis B virus (HBV) and hepatitis C virus (HCV). The product label instructions stated, "To Disinfect and deodorize hard, nonporous surfaces: If present, use a wipe to remove visible soil prior to disinfecting. Unfold wipe and thoroughly wet surface. Allow surface to remain wet for two (2) minutes. Let air dry." A continuous observation was conducted of Nurse #1 and the 100 back hall medication cart during the morning medication pass on 10/23/24 from 7:28 AM to 7:52 AM. Nurse #1 collected supplies (a vial of test strips, a lancet, and an alcohol wipe) and obtained a glucometer from the medication cart in preparation to conduct a blood glucose check for Resident #28. The glucometer was not labeled with a resident's name. Nurse #1 removed an alcohol prep pad from the top drawer of her medication cart. She used the alcohol prep pad and wiped the surface around the test strip insertion site of the glucometer. Nurse #1 was accompanied as she carried the glucometer and supplies to Resident #28's room. While wearing gloves, the nurse wiped the resident's finger with an alcohol pad, used a lancet to obtain a drop of blood from her finger and applied the blood to the test strip inserted into the glucometer. Once the blood glucose results were obtained, Nurse #1 returned to the medication cart with the glucometer and discarded the trash and lancet. Nurse #1 removed an alcohol prep pad from the	F 880	and competency is completed with all licensed nurses, including any agency staff if used□this training and competency will be completed prior to each licensed nurse starting their first shift with any resident. Following initial orientation, training on the Diabetes Management policy and procedure, including the steps and requirements for properly cleaning and disinfecting shared glucose meters before and after each use will then be provided by the Staff Development Coordinator at least annually via a skills/competency fair for all licensed nurses. Any licensed nurse who does not attend this mandatory annual competency assessment during the scheduled time will not be allowed to work hands on with any resident until this has been completed. To ensure compliance in following the required steps for properly cleaning and disinfecting shared glucose meters, the Staff Development Coordinator will conduct audits beginning on 11/18/24 of 6 random licensed nurses on both shifts (3 day shift/3 night shift) weekly X 4 weeks, which will include being able to both verbally review the required steps noted in the Diabetes Management Policy as well as successfully completing all required steps through hands-on observation--concerns during any of these audits will be addressed by the Staff Development Coordinator immediately, including disciplinary action up to and including termination for the safety of residents as necessary. To maintain continued compliance in	

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F 880	Continued From page 36 top drawer of her medication cart. She opened the alcohol prep pad and wiped the surface around the test strip insertion site of the glucometer. Nurse #1 then placed the glucometer on the top of her medication cart. Nurse #1 left the medication cart to administer medications to Resident #28 and returned to the medication cart at 7:41 AM. At 7:44 AM Nurse #1 was observed as she collected supplies (a vial of test strips, a lancet, and an alcohol wipe) in preparation to conduct a blood glucose check for Resident #7. Nurse #1 obtained an alcohol prep pad from the top drawer of her medication cart. She picked up the glucometer that was sitting on the top of her medication cart that had been used to conduct Resident #28's blood glucose check. She opened the alcohol prep pad and wiped the surface around the test strip insertion site of the glucometer. Nurse #1 was accompanied as she carried the glucometer and supplies into Resident #7's room. While wearing gloves, Nurse #1 approached Resident #7 with the glucometer and supplies to check her blood glucose. Nurse #1 was stopped by the surveyor and asked to return to the medication cart. On 10/23/24 an interview was conducted with Nurse #1 at 7:53 AM. Nurse #1 said she had used an alcohol prep pad to clean the glucometer because that was what she thought she was supposed to use. Nurse #1 said an alcohol prep pad or hand sanitizer could be used to clean the glucometer. Nurse #1 removed an individually packaged [brand name] disinfect wipe from the top drawer of the medication cart and stated that it could also be used to clean the glucometer but that it cleaned the glucometer the same as the alcohol prep pad or hand sanitizer would. Nurse #1 said the glucometer was supposed to be	F 880	following the required steps for properly cleaning and disinfecting shared glucose meters, the Staff Development Coordinator will conduct an audit of 6 random licensed nurses on both shifts (3 day shift/3 night shift) monthly X 3 months and then on a routine quarterly basis as part of the ongoing QAPI process. These audits will include being able to both verbally review the required steps noted in the Diabetes Management Policy as well as successfully completing all required steps through hands-on observation. Concerns during any of these audits will be addressed by the Staff Development Coordinator immediately, including disciplinary action up to and including termination for the safety of residents. Findings and results from audits will be reported to the QA&A Committee by the Staff Development Coordinator quarterly.	

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F 880	Continued From page 37 cleaned before and after each use to prevent transmission of infection. She explained she had only cleaned the glucometer around the test strip insertion site with the alcohol prep pad, because that was where the blood sample was inserted. Nurse #1 was unable to specify how she would disinfect the glucometer using the [brand name] disinfecting wipe. On 10/23/24 at 7:57 AM the Risk Management Nurse approached the medication cart during the interview with Nurse #1. The Risk Management Nurse was notified that Nurse #1 had used an alcohol prep pad and cleaned around the test strip insertion site of the glucometer but had not used a disinfectant wipe to disinfect the shared glucometer between resident use. An interview was conducted with the Risk Management Nurse on 10/23/24 at 7:57 AM at the 100 back hall medication cart with Nurse #1. The Risk Management Nurse said an alcohol prep pad could not be used to disinfect the glucometer, and that the entire surface of the glucometer needed to be disinfected not just the area around the test strip insertion site. He stated glucometers were supposed to be disinfected before and after each use. The Risk Management Nurse said the [brand name] disinfectant wipe located on the medication cart was supposed to be used to disinfect the glucometer. He explained the process to disinfect the glucometer was to use the [brand name] disinfectant wipe to wet all the surfaces of the glucometer, let it remain wet for 2 minutes, and then let it air dry. He said the purpose of disinfecting the glucometer was to prevent the transmission of bloodborne pathogens. After the Risk Management Nurse verbalized the process for disinfecting the	F 880		

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glucometer, Nurse #1 stated she should have used the [brand name] disinfectant wipe to disinfect the glucometer.

An observation was conducted on 10/23/24 at 8:00 AM of Nurse #1 disinfecting the shared glucometer. Nurse #1 obtained a [brand name] disinfectant wipe from the top drawer of the medication cart. She unfolded the disinfectant wipe and used it to wipe all the surfaces of the glucometer keeping it wet for 2 minutes. She then placed the glucometer on a paper to let it air dry.

An interview was conducted with the Nurse Practitioner (NP) on 10/24/24 at 12:13 PM. The NP stated that the facility should follow its policy for disinfecting glucometers to prevent transmission of bloodborne pathogens. She stated she was not aware of any resident at the facility who had a bloodborne pathogen diagnosis.

An interview was conducted with the Infection Preventionist (IP) on 10/23/24 at 12:36 PM. She said that glucometers were supposed to be disinfected before and after each use. She said the [brand name] disinfectant wipe was located on the medication cart to disinfect the glucometer. She said glucometers should be disinfected to prevent transmission of bloodborne pathogens because the facility's glucometers were shared. The IP did not know why Nurse #1 did not know how to disinfect the glucometer or had thought it was okay to use an alcohol prep pad to disinfect the glucometer. The IP stated she conducted point of care testing audits for glucometers. She said when she had audited Nurse #1 in September 2024, she had disinfected the glucometer correctly.

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An interview was conducted with the Director of Nursing (DON) on 10/23/24 at 12:56 PM. The DON said the facility's glucometers were shared and stored on the medication cart. She said glucometers needed to be disinfected before and after each use to prevent the transmission of bloodborne pathogens. The DON said the [brand name] disinfectant wipe should be used to disinfect the glucometer not an alcohol prep pad. She said she did not know why Nurse #1 had not disinfected the glucometer and had used an alcohol prep pad instead of a disinfect wipe, except that Nurse #1 might have been nervous.

An interview was conducted with the Administrator on 10/23/24 at 1:20 PM. The Administrator said the facility's glucometers were shared and needed to be disinfected before and after each use. She said the [brand name] disinfectant wipe, not an alcohol prep pad should be used to disinfect the glucometers. The Administrator said the purpose of disinfecting the glucometer was to prevent the transmission of bloodborne pathogens. The Administrator said she did not know why Nurse #1 had not disinfected the glucometer after using it.

A review of the medical diagnoses for current residents at the facility was conducted. There were no residents identified as having diagnoses which included a bloodborne pathogen.

The facility's Administrator was informed of the immediate jeopardy on 10/23/24 at 2:52 PM.

The facility submitted an acceptable credible allegation of immediate jeopardy removal.

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1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

On 10/23/24 at 7:28 am, Nurse #1 failed to properly clean and disinfect one shared blood glucose meter after use for Resident #28 and was then stopped before Resident #7 was tested during a medication pass.

Both Resident #7 and Resident #28 were at risk of suffering from the deficient practice. All residents being care for/medicated by Nurse #1 who required a blood glucose check using a shared glucometer at any time while Nurse #1 was on duty were also at risk from being affected by the deficient practice because Nurse #1 could not verbalize the correct steps to disinfect the glucometer.

The blood glucose meter used by Nurse #1 was properly cleaned and disinfected by the Director of Nursing when she became aware of the initial concern on 10/23/24 at 1:00 pm.

The Director of Nursing reviewed all resident diagnoses to ensure no resident currently has an active diagnosis of any blood borne pathogen on 10/23/24 at 2:09 pm.

Nurse #1 was terminated from employment on 10/23/24 at 4:00 pm to ensure no other residents on her assigned unit have the potential of being affected by continued deficient practice.

2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

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The current policy and procedures for Diabetes Management was reviewed by the Director of Nursing, ADON/Case Management Coordinator, Staff Development Coordinator, Infection Control Preventionist, and Administrator at 3:30 pm to ensure accuracy of procedures following manufacturer's directions.

Between 10/23/24 at 4:30 pm and 10/24/24 at 6:00 pm, training/education was provided to all licensed nursing staff by the Staff Development Coordinator, Infection Control Preventionist, ADON/Case Management Coordinator, and DON on the Diabetes Management Policy and Procedures for properly cleaning and disinfecting shared blood glucose meters before and after each use as well as the significance of doing so for the safety/health of every resident related to the high likelihood for the spread of blood borne pathogens. This training specifically included the brand of disinfectant required, the requirement for the disinfecting of the full surface area of the blood glucose meter itself, and the required length of wet contact time.

No current licensed nurse will be allowed to work prior to receiving this education from the Staff Development Coordinator, Infection Control Preventionist, ADON/Case Management Coordinator, and DON. This training will also be included in the new hire orientation training provided by the Staff Development Coordinator who will be responsible for ensuring this training is completed with all licensed nurses, including any agency staff if used, during initial orientation and prior to starting their first shift.

The MD/Medical Director and Nurse Practitioner

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were both verbally notified of the breach by the Director of Nursing on 10/23/24 at 3:45 pm. The Gaston County Health Department was notified via email by the Director of Nursing on 10/23/24 at 6:45 pm of the breach. The Responsible Party of resident #28 was notified of the breach by the Director of Nursing on 10/23/24 at 7:00 pm.

The Administrator and Director of Nursing are responsible for the implementation and completion of the removal plan.

The immediate jeopardy was removed on 10/25/24.

On 10/24/24 the facility's credible allegation of immediate jeopardy removal was validated by the following:

An onsite validation was completed on 10/24/24 at the facility. The validation was evidenced by nurse and administrative interviews conducted that included the required infection control practices for glucometers. Interviews with nurses revealed they had received education on the facility's glucometer disinfection policy/ procedures. Nurses were able to state the correct process for disinfecting the facility's shared glucometers, including the correct product to use and wet contact time of two minutes. Nurses were able to verbalize glucometers needed to be disinfected before/ after each use to prevent the transmission of bloodborne pathogens. Observations were conducted and revealed nurses were correctly disinfecting the facility's shared glucometers according to the facility's policy/ procedures. Any current staff, agency staff, or new staff who had not received education and competency validation on glucometer

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F 880	Continued From page 43 disinfection would not be allowed to work by the facility until the education and competency had been completed. The immediate jeopardy removal date of 10/25/24 was validated.	F 880		