STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	01/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal	F 156		1/26/15

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

Electronically Signed | 01/23/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156		

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F 156	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview, the facility failed to provide (1) the reason for Medicare Non-coverage and (2) contact information for requesting an immediate appeal for 3 of 3 sampled residents (Residents #36, #56, and #71) who were issued notice of Medicare Non-coverage. The findings included: 1. Resident #36 was issued a "Notice of Medicare Non-coverage" on 10/22/14. The notice did not include a reason for coverage to end, nor the name and telephone number of the Quality Improvement Organization (QIO) to contact for an immediate appeal. During an interview on 01/09/2015 8:52 AM, the Social Worker stated she issued the Medicare Non-coverage notices. She indicated that for Resident #36, she did not put the reason for the Non-coverage or the QIO contact information in the notice. 2. Resident #56 was issued a "Notice of Medicare Non-coverage" on 11/25/2014. The notice did not include a reason for coverage to end, nor the name and telephone number of the Quality Improvement Organization (QIO) to contact for an immediate appeal. During an interview on 01/09/2015 8:52 AM, the Social Worker stated she issued the Medicare Non-coverage notices. She indicated that for Resident #56, she did not put the reason for the Non-coverage or the QIO contact information in the notice. 3. Resident #71 was issued a "Notice of Medicare Non-coverage" on 12/09/2014. The	F 156	This Plan of correction is the center□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of Federal and State Law. Residents 36, 56, and 71 still reside at the facility. All current and future Medicare residents that have the potential to be affected will follow this corrective action 1. Non-coverage letters will be completed by center social worker, with copies being provided to the business office and sent to resident/ Responsible party, no less than 48 hour prior to non-coverage effective date. 2. Social Worker, Business office manager, Assistant Business office manager, and Administrator were in-serviced on the regulations and expectations to include the reason for Medicare benefits ending and the Quality Improvement Organization name and contact information in the non-coverage letter by the Regional business office controller on 1/12/2015. 3. All current and future residents will receive non coverage letters with the reason for decertification notification 48	

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F 156	Continued From page 3 notice did not include a reason for coverage to end, nor the name and telephone number of the Quality Improvement Organization (QIO) to contact for an immediate appeal. During an interview on 01/09/2015 8:52 AM, the Social Worker stated she issued the Medicare Non-coverage notices. She indicated that for Resident #71, she did not put the reason for the Non-coverage or the QIO contact information in the notice.	F 156	hours before discharge of therapeutic service effective 1/12/2015. 4. Administrator and/or Business office manager will audit all non-coverage letters and documentation. Administrator and Business Office Manager will audit letters during weekly Medicare meeting using an audit tool and send to the Regional business office consultant. Regional Business Office Consultant and Administrator will make sure the letter contains the resident name and patient number, date letter is issued, QIO contact information, date in which service(s) and type of service(s) that will be discontinued, and the reason for discontinuation. weekly for 30 days then bi-weekly for 30 days then monthly for 60 days. Social Worker will report any delays immediately to Administrator and the Regional Business Office Consultant. Any other issues or trends identified in these audits will be addressed and the plans will be adjusted to ensure continued compliance by re-education of staff and/or counseling. Social Worker will report results of audit to Administrator and Performance Improvement team monthly for 4 months.	
F 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal	F 159		1/26/15

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F 159	Continued From page 4 funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.	F 159		

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F 159	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with staff and responsible parties of residents the facility failed to provide quarterly financial statements for 2 of 2 residents (#47 & #82) who had a facility managed personal funds account (PFA). The findings included: 1. Resident #47 was admitted to the facility on 9/6/11. The quarterly Minimum Data Set dated 11/20/14 revealed he was severely cognitively impaired. On 1/5/15 at 3:19 PM during an interview the responsible party for resident #47 reported she had not received a PFA statement for more than a year. On 1/8/14 at 2:58 PM during an interview the Business Office Manager stated she was responsible for providing the financial statements to the residents or their responsible party. She reported the facility changed management companies on July 31, 2014. She stated the previous company did not provide resident PFA statements for the last quarter which ended June 2014 and the current company had not provided PFA statements for the first quarter which ended September 2014. The last time PFA statements were issued was 6 months ago so the residents or their responsible party had not received statements for 2 consecutive quarters. 2. Resident # 82 was readmitted to the facility on 5/30/14. The quarterly Minimum Data Set dated 11/17/14 revealed she was severely cognitively impaired. On 1/6/15 at 9:06 AM during an interview the responsible party for resident #82 stated she had not received a PFA statement from the facility since readmission.	F 159	This Plan of correction is the center□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of Federal and State Law. Quarterly RFMS statements are to be generated at the end of each quarter by National Data Care and then mailed to center. This was not completed due to corporate changeover but has been corrected. 2014 Quarter 4 statements have been received and have been distributed by business office to residents. Residents #47 and 82 still reside at the facility and have been offered copies of their statements Copies of past statements have been collected from National data care and available upon request. Business Office Manager posted signage reading, Any resident or Responsible party who would like to see past or current quarterly resident trust fund statements please come to the business office. on 1/28/2015. All current and future residents that have the potential to be affected will follow this corrective action 1. Upon receipt of statements the business office mails or delivers statements to the appropriate resident/RP. Residents/RPs is then	

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F 159	Continued From page 6 On 1/8/14 at 2:58 PM during an interview the Business Office Manager stated she was responsible for providing the financial statements to the residents or their responsible party. She reported the facility changed management companies on July 31, 2014. She stated the previous company did not provide resident PFA statements for the last quarter which ended June 2014 and the current company had not provided PFA statements for the first quarter which ended September 2014. The last time PFA statements were issued was 6 months ago so the residents or their responsible party had not received statements for 2 consecutive quarters.	F 159	notified that they can obtain balance information upon request. 2. Business office manager, assistant business office manager, and Administrator were in-serviced on the regulations and expectations by the Regional business office consultant on 1/12/2015. 3. Copies of quarterly statements are maintained in the Business Office for review upon request. Systemic Changes to ensure practice will not reoccur, the Business office manager will monitor the delivery of the quarterly statements and request duplicates if the statements are not delivered 1 week after the end of the quarter. 4. Administrator and Regional business office consultant will audit the presentation/distribution of quarterly statements. Business office manager or Assistant Business office manager will report any other issues or trends identified in these audits to the Administrator and Regional Business Office Consultant and the plans will be adjusted to ensure continued compliance by re-education of staff and/or counseling and contacting National Data Care if problems arise. This issue will be addressed by the Business Office Manager monthly at the Performance Improvement meeting for 6 months.	
F 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey	F 160		1/26/15

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F 160	Continued From page 7 within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on staff interview and financial record review the facility failed to convey the resident's personal funds upon death to the probate jurisdiction administrating the resident's estate or to the executor of the estate for 1 of 3 residents (Resident #16) reviewed for conveyance of funds. The findings included: An undated facility policy titled "Resident Fund Management Services" read in part, "The funds can be released according to state probate laws and health care facility regulations." Resident #16 was readmitted to the facility on 3/24/13 and expired on 10/21/14. A review of Resident #16's personal fund statement revealed the account was closed on 10/22/14 with a check issued in the amount of $1307.68 on 10/23/14. The payee was a funeral home. During an interview with the Business Office Manager on 1/9/15 at 8:37 AM she stated the facility had a policy to send the money to the funeral home instead of the probate court administering the resident's estate. During an interview with the Regional Business Office Consultant on 1/9/15 at 9:00 AM she stated the funds could be sent to the funeral home only if there was a bill from the funeral home present with the statement. During an interview with the Administrator on 1/9/15 at 9:05 AM she stated she thought it was acceptable to send the funds to the funeral home.	F 160	This Plan of correction is the center□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of Federal and State Law. 1. Resident trust policy and procedure as well as NC state requirements were reviewed with Business office manager as well as Administrator on 1/12/2015 by Regional business office consultant. 2. Business office manager, Assistant Business office manager, and Administrator were in-serviced on the regulations and expectations of conveyance of resident funds upon death/discharge by the Regional business office controller on 1/12/15. The regional business office consultant, Business Office Manager, and Assistant Business Office Manager completed an audit of resident accounts that had discharged/deceased for credit balances on 1/12/15. No accounts were affected. 3. Accounts will be monitored and account closure documents will be reviewed	

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F 160	Continued From page 8	F 160	weekly for 30 days, then on the 1st and 20th day of each month by the Business office manager, Administrator, and the Regional business office consultant for 60 days. Review will then continue following this schedule by the Business office manager and the Regional business office consultant indefinitely. Any resident having been discharged and/or deceased and meets resident funds criteria will have funds conveyed or dispersed to the individual or probate jurisdiction administering the resident□s estate within the 30 days. 4. Monitoring process - The Business office manager or designee will report any adverse findings to Administrator and Regional business office consultant immediately and report the results of the audit in the Performance Improvement meeting for the next 4 months.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the	F 371	This Plan of correction is the center□s	1/26/15

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F 371	Continued From page 9 facility failed to make sure a fan blowing air directly on clean and sanitized dishes was clean. The findings included: On 1/8/2014 at 9:35 AM, during an observation of the facility's dishwashing process, a large fan attached to the wall in the kitchen was blowing air directly on dishes that were cleaned, sanitized, and drying, after coming out of the dishwasher. The fan was noted to be unclean with a heavy layer of dust. The dust coated the top and bottom of the fan's grills, with dust "strings" hanging down from the upper and lower fan grills. On 1/8/2014 at 10:25 AM, an interview was conducted with the Dietary Manager (DM). The DM stated she wiped the fan down last Friday, but might have not done a good job. She stated that the fan was taken down and cleaned every week by maintenance, and she had a log to track it. A review of the log showed that a maintenance request for cleaning of the kitchen dish room fan was written by the DM on 10/29/2014. The DM stated there was a December log, but it must have been taken by the last maintenance man that recently quit working at the facility. The DM stated the fan was dirty and needed to be cleaned, and she was going to find the maintenance man to take the fan down and clean it.	F 371	credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of Federal and State Law. 1. Fan in kitchen was removed from wall mounting and was cleaned on 1/8/2015. Dishes that were dried by the fan before its cleaning were rewashed and sanitized on 1/8/2015. 2. Dietary staff in-serviced on monitoring the cleanliness of the dish room fan and how to use and document it□s cleanliness on the monitoring log tool by the dietary manager on 1/8/2015 and 1/9/2015. 3. The dish room fan is to be wiped free of debris daily after each use and as needed. A manual detachment of the dish fan from the wall mount and deep cleaning will be done weekly and as needed. Dietary Manager or Assistant Dietary Manager will ensure that the manual detachment request will be placed in the Maintenance log and is completed within 24 hours. 4. The Dietary Manager or Assistant Dietary will conduct daily visual inspections that will be charted everyday for 30 days, then bi-weekly for 30 days then weekly thereafter. Any other issues or trends identified in these audits will be addressed and the plans will be adjusted to ensure continued compliance. Results of the audit will be reported monthly by the	

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F 371	Continued From page 10	F 371	Dietary manager or Assistant Dietary Manager at the Performance Improvement meeting for 6 months.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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.	F 431		1/26/15

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F 431	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to discard expired medications and verify the presence of an expiration date on bottles of acetaminophen on 2 of 4 medication carts (medication carts 3A and 3B). The findings included: The facility policy, last revised April 2007, entitled, "Storage of Medications" read in part, "3. Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed." 1. On 1/8/15 at 2:49 PM, the 3A medication cart was observed in the presence of Nurse #2. One (1) bottle of acetaminophen 500 milligrams (mg) with no expiration date, 1 bottle of acetaminophen 325 mg with an expiration date that read "4" for the month and an illegible ink smear for the year, and 1 package of loratadine 10 mg with an expiration date of 9/14 were in the medication cart. Nurse #2 was interviewed on 1/8/15 at 2:53 PM. She indicated the loratadine should have been discarded in the sharps when expired and that medications with unclear or no marked expiration dates should also be discarded. During an interview on 1/9/15 at 1:51 PM, the Director of Nursing (DON) stated she expected the nurses to discard expired medications and expected stock medications to have an expiration date printed on the bottle by the manufacturer.	F 431	This Plan of correction is the center□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of Federal and State Law. 1. Expired medications and two bottles of acetaminophen without an expiration date were removed from the medication cart immediately on 1/8/2015. Nurse #2 and Nurse # 3 were given 1:1 re-education on Medication Storage by the Director of nursing on 1/8/2015. No resident was identified to be affected. 2. Audit of all medication carts and medication storage room completed on 1/8/2015 by unit managers. No other expired medications found. 3. Nurses were re-educated by the Staff Development Coordinator on Medication Storage per policy, this was complete on 1/19/2015. The pharmacist consultant has been notified of the survey findings on 1/20/2015 and will perform monthly audits of the medication carts and medication room to assist the facility in discarding expired medications. 4. The Unit Managers will audit medication carts 2 times per week for 12 weeks for expired medications and	

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	345336	A. BUILDING _____ B. WING _____	01/09/2015

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F 431	Continued From page 12 The DON added it appeared the date had rubbed off the acetaminophen bottles. 2. On 1/8/15 at 3:02 PM, the 3B medication cart was observed in the presence of Nurse #3. One (1) bottle of Vitamin B6 with an expiration date of 12/14 was in the cart. Nurse #3 indicated it should have been sent back to the pharmacy when expired. During an interview on 1/9/15 at 1:51 PM, the Director of Nursing (DON) stated she expected the nurses to discard expired medications.	F 431	expiration dates. The Pharmacist Consultant will submit a monthly report to the Director of Nursing. The Director of Nursing will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing Staff Development Coordinator, ADON, Quality of Life Coordinator, Dietary Manager, Maintenance Director, Medical Director, Director of Social Services, and Environmental Services.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441		1/26/15

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F 441	Continued From page 13 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, manufacturer specifications and facility policy, the facility failed to disinfect the glucometer before use for 1 of 1 sampled resident (Resident #159) observed getting a blood glucose check. The findings included: The undated facility policy entitled, "Glucometer, Cleaning and Disinfecting," read in part: "General guidelines" "1. Per Centers for Disease Control and Prevention guideline (CDC), if glucometer is shared, clean as needed and disinfect the device after every use according to manufacturer's instructions." "3. Follow manufacturer's instructions on germicidal product/wipe contact time." "Procedure" "5. To disinfect the meter or lancing device: a. Use (brand name) germicidal bleach wipes." "c. Allow the surface of the meter or lancing device to remain wet at room	F 441	This Plan of correction is the center□s credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of Federal and State Law. 1. Nurse #1 was re-educated on 1/9/2015 on Glucometer Cleaning and Disinfecting Guidelines per policy which include General guidelines Per Centers for Disease Control and Prevention following the manufactures instructions on germicidal product wipe/contact time.	

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F 441	Continued From page 14 temperature for five (5) minutes." Manufacturer specifications for (brand name) included, "Contact time for a disinfectant is the amount of time a surface must remain wet with the product to achieve disinfection." The following micro-organisms were listed with the contact times and included in part, "Hepatitis B Virus 30 seconds; Hepatitis C Virus 30 seconds, Human Immunodeficiency Virus Type 1 (HIV-1) 5 minutes, Methicillin Resistant Staphylococcus aureus (MRSA) 5 minutes." On 1/9/15 at 11:45 AM, Nurse #1 was observed preparing to perform a blood glucose check on Resident #159. The nurse wiped the glucometer with the (brand name) bleach wipe from 11:45:45 - 11:47:15 AM and then place it on top of the medication cart to dry. At 11:48:15 the glucometer appeared dry. Nurse #1 took the dry glucometer into the resident's room and performed the blood glucose check. During an interview on 1/9/15 at 11:57 AM, Nurse #1 indicated she believed the glucometer should sit for at least a minute after wiping. On 1/9/15 at 1:54 PM, the Director of Nursing (DON) indicated she expected staff to clean and disinfect the glucometers before and after each use according to policy. The DON stated staff had been instructed to wrap the wipe around the glucometer after wiping so that the surface would stay wet for the required 5 minutes.	F 441	2. Observational audits of Licensed Nurses cleaning and disinfecting blood glucose meters according to the manufactures instructions on germicidal product wipe/contact time began on 1/9/2015 by the Director of nursing and Staff Development coordinator to ensure proper cleaning and disinfecting blood glucose meters following the manufacturer instructions on germicidal product wipe/contact time. 3. Re-education was conducted by the staff Development Coordinator for Licensed Nurses on the proper cleaning and disinfecting of the blood glucose meter following the manufactures instructions on germicidal product wipe/contact time. This re-education was conducted from 1/7/2015-1/19/2015. 4. Observational audits of Licensed Nurses cleaning and disinfecting blood glucose meters following the manufactures instructions on germicidal product wipe/contact time will be conducted by the Assistant Directors of Nursing, Staff Development Coordinator and Director of Nursing. Eight glucometer cleaning and disinfecting audits will be conducted per week for 12 weeks to ensure proper cleaning and disinfecting blood glucose meters following the manufacturer instructions on germicidal product wipe/contact time. 8 audits per week across all shifts to include weekend staff. Any issue identified will be immediately addressed, corrected and the identified staff member will receive immediate re-education. Any other issues or trends identified in these audits will be	

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F 441	Continued From page 15	F 441	addressed and the plans will be adjusted to ensure continued compliance. The DON will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, ADON, Quality of Life Coordinator, Dietary Manager, Maintenance Director, Medical Director, Director of Social Services, and Environmental Services.	