STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	C 04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	**250 BISHOP LANE CONCORD, NC 28025**

(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 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after	F 645		5/15/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/11/2018

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

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F 645	Continued From page 1 being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to submit information for Preadmission Screening and Resident Review (PASRR) for a level II evaluation for 1 of 2 residents reviewed for PASRR (Resident #42). The findings included: Resident #42 was admitted to the facility on 1/26/18 with diagnoses which included: Anxiety,	F 645	Brian Center Cabarrus acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of the CMS Rules of Participation. This plan of correction is submitted as a written allegation of compliance. Preparation and submission	

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F 645	Continued From page 2 bipolar disorder, depression, and schizoaffective disorder. Review of Resident #42's most recent Minimum Data Set (MDS) revealed a comprehensive admission assessment with an Assessment Reference Date (ARD) of 2/2/18 revealed the resident's cognition was moderately impaired. The resident was coded as having felt down, depressed, or helpless for 2-6 days, feeling tired or having little energy for 12-14 days, and for having a poor appetite or overeating for 2-6 days, all of which were during a 2 week period. The resident was coded as having had received antipsychotic medication for 7 of the 7 days during the assessment period. Review of Resident #42's care plan which was initiated on 2/6/18 revealed the resident was care planned as having been an elopement risk, confusion, anti-anxiety medications, antidepressant medication, and antipsychotic medication related to a diagnosis of schizophrenia. Review of Resident #42's Medication Administration Record (MAR) from April 1, 2018 through April 18, 2018 revealed the resident received the following medication: Quetiapine Fumarate tablet 300 milligrams (mg) each evening for a diagnosis of schizoaffective disorder and an order date of 1/26/18. A review was completed of the Social Services, Initial Assessment and History for Resident #42 dated 1/26/18. The diagnoses list in the assessment included schizoaffective disorder. The Social Services Summary note stated the resident was alert and oriented with moderate	F 645	of this plan of correction is in response to the CMS 2567 from the survey conducted on April 16-19, 2018. Brian Center Cabarrus□s response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the statement nor does it constitute an admission that any deficiency is accurate. Further, Brian Center Cabarrus reserves the right to refute any deficiency on this Statement through Informal Dispute Resolution, formal appeal, and/or other administrative or legal procedures. F645 1. The information for Resident #42 was submitted to NCMUST for a level II Preadmission Screening and Resident Review (PASSR) referral on 4/19/18 by the facility social worker. After review of the occurrence it was identified that a facility process for reviewing relevant diagnosis requiring a Preadmission Screening and Resident Review (PASSR) level screening needed focused review and education. 2. On or before 5/15/18, Minimum Data Set staff and Unit Coordinators will audit current residents with diagnosis□ requiring a level 2 Preadmission Screening and Resident Review (PASSR) screening and a screening request submitted by the facility Social Worker to NCMUST. 3. On 5/8/18 the District Director of Care Management educated the facility social worker, administrator, director of nursing, and minimum data set staff on the Preadmission Screening and Resident Review (PASSR) referral process.	

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F 645	Continued From page 3 cognitive impairment. The assessment was digitally signed by the SW on 1/30/18. An interview was conducted with the facility social worker (SW) on 4/19/18 at 2:11 PM. The SW stated there was a possibility Resident #42 may have been a level II PASRR based on her diagnoses, including schizoaffective disorder. The SW stated the resident was one of the residents on a list of residents she had received from the nursing department to resubmit to the North Carolina Medicaid Uniform Screening Tool (NCMUST). The SW stated she had not submitted Resident #42's information to NCMUST for a level II PASRR screen. The SW stated Resident #42 had been admitted in January but she had not submitted the resident's information to NCMUST. The SW explained she did not enter any residents into the NCMUST system until she received notification from nursing or from the MDS nurse of a resident having had a diagnosis which would indicate the need to submit to NCMUST for a level II PASRR. The SW stated the diagnoses which would cause the resident's information to be submitted for a level II PASRR included schizophrenia. The SW further stated if a resident had a serious mental health illness, mental retardation, or conditions related to mental retardation. The SW stated Resident #42 had a diagnosis of schizoaffective disorder. The SW stated she was not aware Resident #42 had a diagnosis of schizoaffective disorder when she was first admitted. The SW further stated she did not look at diagnoses for new residents when they were admitted. The SW stated not submitting the information for Resident #42 to NCMUST for a level II PASRR referral was an oversight on her part.	F 645	4. The Resident Care Management Director/or designee will randomly audit 5 residents chart weekly for 4 weeks and then monthly for 2 months to ensure that all screenings for level 2 Preadmission Screening and Resident Review (PASSR) have been submitted to NCMUST. 5. The Minimum Data Set Coordinator or designee will report findings of the audits to the Quality Assurance Performance Improvement committee monthly for 3 months to determine the need for additional monitoring and/or education. Date of Compliance: 5/15/18	

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F 645	Continued From page 4 An interview was conducted with the Administrator on 4/19/18 at 4:48 PM. The Administrator stated it was his expectation if there was a trigger for a level II PASRR referral, there should have been a process for identifying the need for a referral.	F 645		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance	F 842		5/15/18

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F 842	Continued From page 5 with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to accurately document on the medication administration	F 842	Brian Center Cabarrus acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to	

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F 842

Continued From page 6

record (MAR) for the application of hand splints and skin integrity for 1 of 1 residents reviewed for range of motion (Resident #12).

Findings included:

Resident #12 was admitted to the facility on 1/9/2015 and readmitted 10/24/2015 with diagnoses to include peripheral vascular disease, unspecified sequelae of cerebral infarction and contractures. The most recent Minimum Data Set (MDS) assessment dated 1/23/2018 assessed Resident #12 to be cognitively intact. The MDS assessed her to have limited range of motion (ROM) on one side of her body, upper and lower extremities and she required staff assistance to balance and transfer.

A review of the physician orders for Resident #12 revealed an order dated 3/14/2018 which read, "apply right hand splint at 1500 (3:00 PM) and remove at 2300 (11:00 PM). Check skin for integrity every 2 hours while in place every evening shift related to contracture right hand. Document consistent refusal and notify occupational therapy."

The MAR was reviewed and it was noted the order for the application of splints to Resident #12 was marked as completed 4/1/2018 through 4/16/2018 as evidenced by the initials of nurses. Resident #12 was observed on 4/16/2018 at 10:17 AM. The right hand was noted to have a contracture of the fingers and she was not wearing a splint on her right arm or hand.

An interview was conducted with Resident #12 on 4/16/2018 at 10:17 AM. She reported she was supposed to have a splint applied to her right

F 842

the extent that the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of the CMS Rules of Participation. This plan of correction is submitted as a written allegation of compliance. Preparation and submission of this plan of correction is in response to the CMS 2567 from the survey conducted on April 16-19, 2017.
Brian Center Cabarrus' response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the statement nor does it constitute an admission that any deficiency is accurate. Further, Brian Center Cabarrus reserves the right to refute any deficiency on this Statement through Informal Dispute Resolution, formal appeal, and/or other administrative or legal procedures.
F842
1. On 4/19/18 the facility MD was notified that the hand splint application and skin integrity monitoring was not being accurately documented. The Unit Coordinator submitted a therapy screening for occupational therapy and the current splint order was discontinued. On 4/19/18 the rehab program manager (occupational therapist) screened resident #12. After reviewing the occurrence it was determined that there was uncertainty whether the resident or staff was donning and doffing Resident #12s hand splint.
2. On 4/19/18 Nurse Management completed an audit of residents with splints to ensure that the splint was in place and documented on the Medication Administration Record. Medication

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F 842	Continued From page 7 hand and arm, but it was not applied for her by staff. Resident #12 was observed 4/16/2018 at 3:50 PM. She was not wearing a splint on her right arm or hand. A review of the MAR for 4/17/2018 revealed the order for the applications of splints was initialed by the nurse that date as completed. An observation of Resident #12 was conducted on 4/17/2018 at 4:36 PM. She was not wearing a splint on her right arm or hand. A review of the MAR for 4/18/2018 revealed the order for the applications of splints was initialed by the nurse that date as completed. Resident #12 was observed on 4/18/2018 at 4:34 PM. She was not wearing a splint on her right arm or hand. Resident #12 was interviewed on 4/18/2018 at 3:00 PM and she reported the arm splint was not applied to her right arm on 4/17/2018. Unit manager #2 was interviewed on 4/19/2018 at 11:49 AM. Unit Manager #2 reported she was not aware the splints had not been applied to Resident #12 and was not certain why this was not completed. Nurse #1 was interviewed on 4/19/2018 at 3:00 PM. He reported he was very familiar with Resident #12. He confirmed he had been assigned to Resident #12 on 4/3-9/2018, 4/11-13/2018, 4/15/2018 and 4/17-18/2018 on the 3:00 PM- 11:00 PM shift. He reported he did not apply the splint to Resident #12, but he initialed	F 842	Administration Record was also reviewed to ensure that skin integrity check was documented. 3. Beginning 5/4/18 but no later than 5/15/18 Area Staff Development Coordinator or designee will educate Licensed Nurses on accurate documentation. Any Licensed Nurses that have not received education by 5/15/18 will receive education prior to working their next scheduled shift. Newly hired Licensed Nurses will receive education during orientation. 4. Nurse Management/or designee will audit 5 residents chart weekly for 4 weeks then monthly for 2 months to ensure accurate documentation on the medication administration record for the application of hand splints and monitoring skin integrity . 5. The Director of Nursing/or designee will report findings to the QAPI committee monthly for 3 months to determine the need for additional monitoring and/or education. Date of Compliance: 5/15/18	

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F 842	Continued From page 8 the MAR at the end of his shift when he would see the splint on Resident #12. He concluded by stating Resident #12 usually applied the splint at bedtime. Nurse #2 was interviewed on 4/19/2018 at 3:51 PM. She reported she had been performing audits on charts and discovered Resident #12 had a splint, but no orders for staff to check her skin. Nurse #2 reported she had put the order into the system for the nurses to check her skin during the time Resident #12 wore the splint. The Therapy Director was interviewed on 4/19/2018 at 4:00 PM. He reported it was his expectation that orders for splints were followed as ordered.	F 842		
F 880 SS=D	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	F 880		5/15/18

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F 880	Continued From page 9	F 880		

providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.

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F 880 Continued From page 10
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on record review, observations and staff interviews the facility failed to maintain infection control protocol as evidenced by the failure of staff to wash their hands between residents during a medication pass (Resident #26 and 54) and the failure to clean equipment/glucometer between residents (Resident #26 and 168).

Findings included:

a. The facility training attendance log for an in-service "Infection Control" dated 12/28/2017 was reviewed and Nurse #1 signature was noted.

An attendance form for an in-service "Handwashing" dated 1/24/2018 was reviewed and Nurse #1 signature was noted.

The facility Resident Care Policies "Hand Hygiene" dated 2012 was reviewed. The policy read, in part, "using an alcohol-based hand rub is appropriate for decontaminating the hands before direct patient contact, before putting on gloves, after removing gloves and after contact with inanimate objects in the patient ' s environment".

A medication administration was observed on 4/18/2018 at 4:25 PM with Nurse #1. The nurse prepared the medication for Resident #26 and applied gloves at the medication cart. He entered

F 880

Brian Center Cabarrus acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of the CMS Rules of Participation. This plan of correction is submitted as a written allegation of compliance. Preparation and submission of this plan of correction is in response to the CMS 2567 from the survey conducted on April 16-19, 2017.
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F880
1. On 4/18/2018 Nurse #1 was educated on hand hygiene and glucometer cleaning. It was identified during the education and leadership interview of Nurse #1 that Nurse #1 did not understand current infection control

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 880

Continued From page 11

the room and administered the oral medication and then checked the resident ' s blood glucose level. He removed his gloves and stated he needed to administer insulin. Nurse #1 did not perform hand hygiene after removing his gloves.

Nurse #1 prepared insulin for administration for Resident #26. Nurse #1 donned gloves at the medication cart and entered the room, administered insulin to Resident #26 and removed his gloves. Nurse #1 did not perform hand hygiene before preparing the insulin or after exiting Resident #26 ' s room.

Nurse #1 noted Resident #26 did not have Novolog insulin in the medication cart to administer for sliding scale coverage. Nurse #1 went to the medication room to attempt to locate stock insulin for Resident #26. He was unable to find insulin, so he exited the medication room and went to the nurse ' s station to place a call to the pharmacy to order the insulin for Resident #26. He returned to the medication cart to prepare medications for Resident #54. Nurse #1 did not perform hand hygiene after returning to the medication cart.

Nurse #1 was interviewed on 4/18/2018 at 4:49 PM. He reported that he had not performed hand hygiene after administering the oral medication and checking the blood glucose of Resident #26 because he did not do much for her and he had worn gloves during the blood glucose check.

Unit Manager #1 was interviewed on 4/18/2018 at 4:55 PM. She reported Nurse #1 should perform hand hygiene after each medication pass and after checking blood glucose levels.

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practices.
2. On or before 5/15/18 licensed nurses will be observed for hand hygiene and glucometer cleaning by nursing administration. Any licensed nurses that have not received education by 5/15/18 will be educated prior to working their next scheduled shift. Any newly hired licensed nurses will receive education during orientation.
3. Beginning 5/4/18 but no later than 5/15/18 Area Staff Development Coordinator or designee will educate Licensed Nurses on proper hand hygiene and glucometer cleaning.
4. Nurse Management/or designee will randomly audit 1 Licensed nurse weekly for 4 weeks then 1 licensed nurse monthly for 2 months for proper hand hygiene and glucometer cleaning.
5. The Director of Nursing/or designee will report findings to the Quality Assurance Performance Improvement Committee monthly for 3 months to determine the need for additional monitoring and/or education.
Date of Compliance: 5/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	C 04/19/2018

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BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	**250 BISHOP LANE CONCORD, NC 28025**

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F 880	Continued From page 12 The Director of Nursing (DON) was interviewed on 4/19/2018 at 9:55 AM. She reported it was her expectation that nurses performed hand hygiene after proving care, passing medications or checking blood glucose levels for patients. The Infection control nurse was interviewed on 4/19/2018 at 3:08 PM. She reported she was not certain why Nurse #1 did not perform hand hygiene after administering medications to Resident #26. She reported she was planning an in-service on handwashing protocols. b. The facility Resident Care Policies "Glucometer decontamination" was reviewed. The policy read, in part, " ... glucometers shall be decontaminated with the facility approved wipes following use on each resident ... apply gloves, remove disinfectant wipe, wipe the monitor and ensure it is visibly wet; follow the wipe manufacturer ' s instructions for the length of time the monitor must remain wet, allow monitor to air dry." The disinfectant wipe packaging was reviewed and it revealed contact time to disinfect hard, nonporous surfaces for bacteria was 30 seconds; bloodborne pathogens, 1 minute; gastrointestinal viruses, tuberculosis and fungi, 3 minutes. A medication administration was observed on 4/18/2018 at 4:25 PM with Nurse #1. The nurse applied gloves at the medication cart and then checked Resident #26 ' s blood glucose level in her room. He removed his gloves and stated he needed to administer insulin to the resident. He returned to the medication cart and placed the glucometer on the top of the cart. He did not disinfect the glucometer.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	C 04/19/2018

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F 880	Continued From page 13	F 880		

Nurse #1 prepared the glucometer for use Resident #168 on 4/18/2018 at 4:58 PM. He had not disinfected the glucometer.

Nurse #1 was interviewed on 4/18/2018 at 4:58 PM. He reported he was not certain why he had not disinfected the glucometer after using it on Resident #26. He reported he would use an alcohol prep pad to clean the glucometer.

The Unit Manager #1 was interviewed on 4/18/2018 at 4:59 PM. She reported disinfectant wipes were on the medication cart for use on the glucometer. She reported the glucometers were wiped down and to remain wet for 30 seconds and were allowed to air dry. Unit Manager #1 concluded by reporting glucometers should be disinfected after each use.

The DON was interviewed on 4/19/2018 at 9:55 AM. She reported it was her expectation for all nurses to follow infection control procedures for disinfecting glucometers.

The Infection control nurse was interviewed on 4/19/2018 at 3:08 PM. She reported she was not certain why Nurse #1 did not disinfect the glucometer after use on Resident #26. She reported she was planning an in-service on disinfecting equipment, including glucometers.