STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345375	A. BUILDING _____ B. WING _____	06/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT SCOTLAND MANOR	920 JR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874

(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 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication	F 636		7/5/18

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

Electronically Signed | 06/22/2018

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F 636	Continued From page 1 with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a comprehensive Minimum Data Set (MDS) assessment for 2 of 5 residents reviewed for admission (Resident #17 and #199). Findings included: 1. Resident #17 had been readmitted to the facility post hospitalization on 5/11/18. Her diagnoses included diabetes, hypertension, schizoaffective disorder, anxiety and glaucoma. A Significant Change in Status (SCS) MDS assessment with an Assessment Reference Date (ARD, the last day of the MDS 7 day look back period) of 5/18/18 was scheduled.	F 636	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 soley because it is required by the provisions of Federal and State law. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to have a backup plan in place for unexpected/emergency absences of Minimum Data Set (MDS)	

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F 636	Continued From page 2 On 6/06/18 Resident #17's SCS MDS assessment was observed in the electronic medical record (EMR) as "in progress" and not completed. On 6/06/18 at 4:00 PM an interview was conducted with the MDS nurse. The nurse stated Resident #17 had returned from the hospital in a weakened condition and a SCS assessment had been scheduled. She stated Resident #17's SCS assessment should have been completed and closed by the 14th day after the ARD which was 6/01/18. The MDS nurse stated she had been on unscheduled leave with an illness and getting coverage for completing the assessments was difficult. On 6/06/18 at 4:15 PM an interview with the Director of Nursing (DON) was conducted. The DON stated it was her expectation that MDS assessments be completed on time. 2. Resident #199 had been admitted to the facility on 5/16/18. His diagnoses included hemiparesis, muscle weakness, hypertension, anemia, diabetes, recurrent depressive disorder, chronic kidney disease and peripheral vascular disease. Resident #199's Admission MDS assessment with an Assessment Reference Date (ARD, the last day of the MDS 7 day look back period) of 5/23/18 was scheduled. On 6/06/18 Resident #199's Admission MDS assessment was observed in the electronic medical record (EMR) as "in progress" and not completed. On 6/06/18 at 4:00 PM an interview was	F 636	Coordinator. MDS Coordinator failed to notify Administrator, Director of Nurses, or VP of Clinical Reimbursement that MDS were out of compliance. Upon return to work MDS coordinator did not immediately ensure that MDSs were brought back into compliance. MDS completion out of compliance with Accordius standard to have MDS completed within 7 days of ARD. MDSs for resident # 16 and #199 have been completed and submitted. The procedure for implementing the acceptable plan of correction for the specific deficiency sited. An audit of all resident□s records will be completed to ensure that all MDS and care plans have been completed timely by 6/29/2018. Audits will be completed by DON, Unit Manager, or Corporate nurse. Any discrepancies found during audits will be corrected. Director of Nursing and Unit Manager will be trained/inserviced by the Vice President of Clinical Reimbursement on MDS completion/comprehensive assessments per the RAI manual.(Date to be completed by 7/5/2018) Accordius Health at Scotland Manor is in the process of recruiting a new MDS Coordinator and appropriate training will be provided once hire occurs. The monitoring procedure to ensure that	

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F 636	Continued From page 3 conducted with the MDS nurse. The nurse stated Resident #199 had been a new admission and the Admission MDS assessment had been scheduled for 5/23/18. The nurse stated the assessment had not been completed and closed by the 14th day after admission which was 5/29/18. The MDS nurse stated she had been on unscheduled leave with an illness and getting coverage for completing the assessments was difficult. On 6/06/18 at 4:15 PM an interview with the Director of Nursing (DON) was conducted. The DON stated it was her expectation that MDS assessments be completed on time.	F 636	the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. All new admissions/readmissions MDS will be audited by the DON, Unit Manager, or Corporate Nurse weekly for four weeks and then monthly until the Quality Assurance and Improvement Committee (QAPI) determines that the process is in compliance and that sustained compliance is achieved. A subcommittee of the QAPI committee will meet weekly for four weeks to review audits to ensure compliance. All audits will then be reviewed in the monthly QAPI meeting; any necessary changes will be made to the plan to ensure compliance is achieved and sustained. Title of person responsible for implementing acceptable plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		7/5/18

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F 656	Continued From page 4 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 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop comprehensive care plans in the areas of activities of daily living	F 656	Plan for correcting specific deficiency. The process that led to deficiency cited.	

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F 656	Continued From page 5 (ADLs), risk for falls, risk for skin break down, high risk medication use and medical conditions requiring monitoring for 1 of 18 residents reviewed (Resident #199). Findings included: Resident #199 had been admitted to the facility on 5/16/18. His diagnoses included hemiparesis, muscle weakness, hypertension, anemia, diabetes, recurrent depressive disorder, chronic kidney disease and peripheral vascular disease. Baseline care plans dated 5/17/18 were observed in Resident #199 ' s medical record. One nutrition comprehensive care plan initiated on 5/29/18 was also observed. Resident #199 ' s Admission MDS assessment with an Assessment Reference Date (ARD, the last day of the MDS 7 day look back period) of 5/23/18 was scheduled. The assessment was observed in the electronic medical record (EMR) as "in progress" and not completed. On 6/06/18 at 4:00 PM an interview was conducted with the MDS nurse. The nurse stated Resident #199 had been a new admission on 5/16/18. The nurse stated comprehensive care plans should be completed for new residents by the 21st day after admission which was 6/05/18. She also stated comprehensive care plans usually included ADLs, risk for falls, risk for skin break down, activities, medication use and monitoring. On 6/06/18 at 4:15 PM an interview with the Director of Nursing (DON) was conducted. The DON stated it was her expectation that comprehensive care plans be completed on time.	F 656	The facility failed to have a backup plan in place for unexpected/emergency absences of MDS Coordinator. MDS Coordinator failed to notify Administrator, Director of Nurses, or VP of Clinical Reimbursement that care plan was out of compliance. MDS Coordinator failed to ensure that MDS was completed timely in order to facilitate development of care plan for resident # 199. Completion of care plan for resident #199 was not in compliance. Care Plan for resident #199 has been completed and is in place. The procedure for implementing the acceptable plan of correction for the specific deficiency sited. Comprehensive Care Plan has been developed for resident # 199 in the areas of activities of daily living(ADLs), risk for fall, risk for skin break down, high risk medication use and medical conditions requiring monitoring. An audit of all resident□s records will be completed by DON or her designee to ensure that all MDS and care plans have been completed timely by 6/29/2018. Any discrepancies found during audit will be corrected. Director of Nursing and Unit Manager will be trained by the Vice President of Clinical Reimbursement on MDS and care plan completion. (Date to	

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F 656	Continued From page 6	F 656	be Completed by 7/5/2018) The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. All new admissions/readmissions care plans will be audited by DON, Unit Manager or Corporate Nurse weekly for four weeks and then monthly until the Quality Assurance and Improvement Committee (QAPI) determines that the process is in compliance and that sustained compliance is achieved. A subcommittee of the QAPI committee will meet weekly for four weeks to review audits to ensure compliance, audits will be reported to the committee by the DON. All audits will reported on in monthly QAPI meeting by the DON where they will be reviewed by committee; any necessary changes will be made to the plan to ensure compliance is achieved and sustained. Title of person responsible for implementing acceptable plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	

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F 761	Continued From page 7	F 761		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to secure 1 of 2 medication carts (North Hall). Findings included: On 6/06/18 at 4:23 PM the North Hall medication cart was observed parked against the wall between rooms 202 and 204. The cart lock was	F 761	Plan for correcting specific deficiency. The process that led to deficiency cited. Facility failed to ensure that nurse # 1 secured medication cart for 1 of 2 medication carts. Nurse #1 immediately ensured that cart was locked. Nurse #1 was inserviced on	7/5/18

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F 761	Continued From page 8 observed in the unlocked position (a red dot is visible on the side of the lock when in the unlocked position). No staff were observed in the hallway and the door to room 202 was slightly open. A few moments later Nurse #1 was observed exiting room 202. On 6/06/18 at 4:26 PM an interview was conducted with Nurse #1. The nurse stated she had accidently left the cart unlocked and it should have been locked when she walked away. On 6/07/18 at 9:18 AM an interview with the Director of Nursing (DON) was conducted. The DON stated it was her expectation that medication carts be locked when out of the eye sight of the nurse.	F 761	"Security of Medication Cart" on 6/7/2108 by Unit Manager. The procedure for implementing the acceptable plan of correction for the specific deficiency sited. All nurses are being inserviced by DON and/or Unit Manager on policy for "Security of Medication Cart," which includes ensuring that medication cart is locked when out of eyesight of nurse. In servicing will be completed by 6/18/2018. Any nurse having not received this education by 6/18/2018 will receive training prior to working their next scheduled shift. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements Random audits will be conducted by monitoring medication carts on the hallway to ensure that they are locked and secured when out of eye site of the nurse. DON, Unit Manager or Department Manager trained by DON will conduct the audits no less than one time per day for five days a week for four weeks on all units and rotating shifts. The monitoring will continue monthly for three months and then quarterly until the QAPI committee	

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F 761	Continued From page 9	F 761	determines that sustained compliance is achieved. The audit tools will be reviewed weekly by a subcommittee of the QAPI committee for four weeks and then monthly by the QAPI committee to ensure sustained compliance. Any negative results from audits will result in additional training and adjustments to plan as needed. Title of person responsible for implementing acceptable plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee previously put in place. This failure was related to non-compliance at the regulatory grouping of 483.21 (comprehensive care plans) on three consecutive	F 867	Plan for correcting specific deficiency. The process that led to deficiency cited. QAPI committee failed to correct all areas included in 483.21(comprehensive care plans) and 483.80(infection control) as addressed earlier in the plan of correction.	7/5/18

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F 867	Continued From page 10 annual recertification surveys, which was recited on the current 6/7/2018 annual recertification survey. This failure was also related to non-compliance at the regulatory grouping of 483.80 (infection control) on two consecutive annual recertification surveys which was recited on the current 6/7/2018 annual recertification survey. The facility's continued failure during the recertification surveys showed a pattern of the facility's inability to sustain an effective QAA program. The findings included: 1.This tag is cross referenced to: 483.21 Develop/Implement Comprehensive Care Plan: Based on record review and staff interviews, the facility failed to develop comprehensive care plans in the areas of activities of daily living (ADLs), risk for falls, risk for skin break down, high risk medication use and medical conditions requiring monitoring for 1 of 18 residents reviewed (Resident #199). 483.21 was originally cited during the July 2016 recertification survey for failing to develop a care plan for a resident using an anti-depressant. 483.21 was also cited during the July 2017 recertification survey for failing to develop a care plan for a resident with severe constipation and rectal impaction, and failing to develop a care plan for a resident receiving an anti-psychotic medication. During an interview on 6/7/2018 at 9:15 AM, the Administrator stated all the care plans were audited after the 2017 recertification survey to be sure they were up to date, and random audits had been completed since then by the Director of	F 867	Corrective action has been implemented for residents having been identified as affected by the deficiencies cited in these areas as previously stated in the plan of correction. The procedure for implementing the acceptable plan of correction for the specific deficiency sited 483.21 All new admissions/readmissions care plans will be audited by DON, Unit Manager or corporate nurse weekly for four weeks and then monthly until the Quality Assurance and Improvement Committee (QAPI) determines that the process is in compliance and that sustained compliance is achieved. A subcommittee of the QAPI will meet weekly for four weeks to review audits to ensure compliance,audits will be brought to the meeting by the DON. All audits will then be reviewed in the monthly QAPI meeting,audits will be reported to the committee by the DON; any necessary changes will be made to the plan to ensure compliance is achieved and sustained. 483.80 A new policy and procedure has been put in place-"Glucometer Use and Cleaning." All licensed nurses will receive inservice on the updated policy/procedure for "Glucometer Use and Cleaning" which includes instructions for cleaning/disinfecting glucometer by	

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F 867	Continued From page 11 Nursing. The Administrator stated the Minimum Data Set (MDS) nurse had an unexpected hospitalization recently, but the care plans should have been completed timely. 2. This tag is cross referenced to: 483.80 Infection Prevention and Control: Based on observation, staff interviews, and record review the facility failed to disinfect glucometers per the manufacturer's recommendations after use for 2 of 2 residents (resident #17, and resident #45) observed for blood sugar checks. 483.80 was originally cited during the July 2017 recertification survey for failing to wash hands during medication pass. During an interview on 6/7/2018 at 9:15 AM, the Administrator stated education was completed on hand washing after the 2017 recertification survey, and follow up on infection control in general was completed. The Administrator stated the facility did not have a Quality Improvement Plan in place for glucometer disinfection, but random audits had been completed by the Unit Manager.	F 867	6/29/2018. The inservice will be conducted by the DON and/or Unit Manager. Any licensed nurse not receiving inservice on process by (6/29/2018) will receive the education prior to working their next scheduled shift. Glucometers have been ordered to provide a single glucometer for use with each individual resident requiring finger stick blood sugar checks.(6/29/2018) The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency sited remains corrected and/or in compliance with the regulatory requirements A subcommittee of the QAPI committee including the Administrator, Director of Nurses, Unit Manager, Director of Social Work, MDS Coordinator and as needed the Dietary Manager, Director of Housekeeping, and Maintenance Director will meet weekly to review audits and education. The subcommittee will determine when and what additional education/audits need to be initiated to ensure that compliance is achieved and sustained. Subcommittee will meet weekly for at least four weeks, and then monthly these areas will continue to be reviewed and addressed in the QAPI committee meeting until it is determined that sustained compliance is achieved. Random reviews will then be completed to ensure that compliance is sustained. If any signs of failed compliance are	

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	345375	A. BUILDING _____ B. WING _____	06/07/2018

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ACCORDIUS HEALTH AT SCOTLAND MANOR	920 JR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874

(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 867	Continued From page 12	F 867	identified the subcommittee will be reactivated to determine what additional plans need to be put in place to achieve sustained compliance. Title of person responsible for implementing acceptable plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
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 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		7/5/18

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F 880	Continued From page 13 §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 infection.	F 880		

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F 880	Continued From page 14 §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 observation, staff interviews, and record review the facility failed to disinfect glucometers per the manufacturer's recommendations after use for 2 of 2 residents (resident #17, and resident #45) observed for blood sugar checks. The findings included: The facility's policy titled Cleaning and Disinfection of Resident-Care Items and Equipment dated July 2014 read: "4. Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturers' instructions." Glucometer manufacturer's recommendations for cleaning and disinfecting were reviewed, and the facility used the recommended germicidal/disinfectant wipes. The instructions read: "4. . . .Allow the surface of the meter to remain wet at room temperature for the contact time listed on the wipe's directions for use. The manufacturer germicidal/disinfectant wipe instructions were visible on the wipe container and read: "5. . . . a 3-minute contact time is required to kill Clostridium difficile spores. Reapply as necessary to ensure that the surface remains wet for the entire contact time. 6. Allow surface to air dry and discard used wipe." On 6/5/2018 at 11:45 AM, Nurse #3 took a glucometer out of the medication cart drawer and readied her supplies for a blood glucose check.	F 880	Plan for correcting specific deficiency. The process that led to deficiency cited. Facility failed to ensure that nurse # 3 ensured glucometer was disinfected per manufacturer□s recommendation. Glucometers not disinfected properly by nurse # 3 were immediately disinfected by Unit Manager. Nurse #3 has received coaching/counseling and reeducation by Unit manager on Policy and Procedure and Manufacturer□s instructions for cleaning/disinfecting of glucometer. The procedure for implementing the acceptable plan of correction for the specific deficiency sited. A new policy and procedure has been put in place-"Glucometer Use and Cleaning." All licensed nurses will receive inservice on the updated policy/procedure for "Glucometer Use and Cleaning" which includes instructions for cleaning/disinfecting glucometer by 6/29/2018. The inservice will be conducted by the DON and/or Unit Manager. Any licensed nurse not receiving inservice on process by (6/29/2018) will receive the education prior to working their next scheduled shift.	

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F 880	Continued From page 15 The nurse entered Resident #17's room and sanitized her hands, donned gloves and performed the blood sugar check. The nurse went back to the medication cart took a disinfectant wipe out of the container, wiped the glucometer off for less than 10 seconds at 11:51 PM and laid it on a clean tissue. The glucometer was completely dry by 2 minutes later. Immediately following, Nurse #3 picked up a 2nd glucometer lying on a tissue on top of the medication cart and proceeded to perform a blood glucose check on Resident #45. At 12:05PM, the nurse wiped the 2nd glucometer with a disinfectant wipe for less than 10 seconds and laid it on a clean tissue. The glucometer was completely dry within 2 minutes. An interview was conducted on 6/5/2018 with Nurse #3 immediately following the cleaning of the 2nd glucometer. The nurse stated she rotated the 2 glucometers between the residents, and was trained to wipe the glucometer off and set it on a clean tissue to dry. After looking at the instructions on the disinfectant wipes, nurse #3 stated the whole process should take 4 minutes, but she did not think the surface was wet for 3 minutes. On 6/5/2018 at 12:20 PM, an interview with the Unit Manager was conducted. The Unit Manager stated the glucometer should be wiped off with a disinfectant wipe, and then wrapped in a disinfectant wipe, and placed in a clean plastic cup for 3 to 5 minutes, and then let air dry completely. On 6/5/2018 at 2:44 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she expected the nurse to keep the glucometer wet with the disinfectant wipe for	F 880	Glucometers have been ordered to provide a single glucometer for use with each individual resident requiring finger stick blood sugar checks.(6/29/2018) The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency sited remains corrected and/or in compliance with the regulatory requirements DON, Unit Manager, and/or nurse trained to conduct audit will conduct random audits of nurse□s following blood sugar checks for proper cleaning/disinfecting of glucometers according to Policy- "Glucometer Use and Cleaning." The audits will be conducted no less than one (1) time per day five(5) times per week for four weeks on all units and rotating shifts. The monitoring will then continue monthly until the QAPI committee determines that sustained compliance is achieved. The audit tools will be reviewed weekly by a subcommittee of the QAPI committee for four weeks and then monthly by the QAPI committee to ensure sustained compliance. Any negative results from audits will result in additional training and adjustments to plan as needed. Title of person responsible for implementing acceptable plan of correction.	

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F 880	Continued From page 16 3 minutes as specified on the manufacturer recommended wipes, and let air dry before using again.	F 880	The Administrator is responsible for implementation and completion of the acceptable plan of correction.	