STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. BUILDING _____ B. WING _____	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE NASHVILLE, NC 27856

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to immediately discard or secure a controlled medication that had been prepared but not given for 1 of 1 residents (Resident #41) by leaving the controlled medication on the top of the medication cart. Findings included: Resident #41 was admitted to the facility on 9/7/18 with active diagnoses that included; Recurrent Falls, Pelvic Fracture, Sacrum Fracture, Muscle Weakness, Malnutrition, Diabetes, Chronic Obstructive Pulmonary Disease, Hypertension, and Anxiety. A review of the most recent Minimum Data Set (MDS) dated 9/14/18, coded as an Admission Assessment, indicated the resident is cognitively intact with adequate vision and hearing. The MDS also indicated that Resident #41 exhibited no behaviors and rejection of care occurred 1 to 3 days during the MDS review period. A review of the physician's orders dated 9/15/18 revealed an order for Xanax (Alprazolam) 0.25mg	F 689	Resident #41 was at risk related to unsupervised Xanax left within access on the medicine cart. On 10/10/18, the nurse was immediately reeducated when this incident was reported. Current mobile residents would be at risk for accidental ingestion of unsupervised Xanax left within their reach on the medicine cart if this practice were to reoccur. Current licensed nurses have been educated concerning the appropriate chain of custody and securing of Xanax. This education included the expectation that if any controlled medication required witnessed wasting, that it would be wasted prior to moving on with further tasks and was completed on 10/31/18. The Director of Nursing or designee will observe med pass during the administration of controlled medication for each nurse as part of the validation of the efficacy of the education. Starting 10/31/18, The Director of Nursing or designee will observe med pass during the administration of controlled medication for random nurses on random shifts daily	11/2/18

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

Electronically Signed | 11/01/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. BUILDING _____ B. WING _____	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE NASHVILLE, NC 27856

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 1 one tablet by mouth two times a day for Anxiety. On 10/10/18 at 06:30 AM an observation was conducted of Nurse #2 removing Xanax (Alprazolam) 0.25mg from the med cart for Resident #41. Upon entering Resident #41's room the nurse realized the resident was sleeping, she returned to the med cart and placed the Xanax (Alprazolam) 0.25mg on top of the med cart and stated I will waste this with the LPN when I get down the hall. Nurse #2 then left the Xanax (Alprazolam) 0.25mg in a soufflé cup sitting unsupervised on top of the med cart and entered another residents room while leaving the Xanax out of her view the entire time. On 10/10/18 at 06:32 AM an interview was conducted with Nurse #2, she stated that she should not have left the Xanax 0.25mg sitting unsupervised on top of the med cart. On 10/11/18 at 02:54 PM an interview was conducted with the Director of Nursing (DON). She stated that the nurse should not have left the Xanax sitting unattended on the med cart. She stated that it was her expectation that the nurses are not leaving medications unsupervised on the med cart. On 10/11/18 at 03:00 PM an interview was conducted with the Administrator. He stated that it was his expectation that the nurses were following safe medication administration practices and that he will address this with the staff.	F 689	for 7 days, then weekly for 11 weeks. The Director of Nursing will report the findings of the monitoring to the monthly QA committee meeting for review and recommendations for the duration of the monitoring period. We allege compliance on 11/2/18.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General.	F 757		11/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. BUILDING _____ B. WING _____	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE NASHVILLE, NC 27856

(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 757	Continued From page 2 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, and Pharmacist interviews, the facility failed to maintain residents drug regimen free of duplicative medications for 2 of 5 residents (Resident #33 and #21) sampled for unnecessary medications. Findings included: 1.Resident #33 was admitted to the facility on 2/23/15 with active diagnoses that included; Abnormal Posture, Hypothyroidism, Diabetes, Anemia, Depression, Hypertension, Reflux, Irritable Bowel Syndrome, and Left-Hand Contractures.	F 757	On 10/10/18 the Zyrtec orders for Resident #33 have been reviewed and clarified to ensure that there is only one order and it does not exceed the recommended daily dose. There were no ill effects from the duplication of administration of these medications. On 10/11/18, the Omeprazole and Nexium orders for Resident #21 were reviewed and clarified to ensure that there is only one order and it does not exceed the recommended daily dose. There were no ill effects from the duplication of administration of these medications. Residents receiving medications are at risk for duplicate orders. On 10/12/18 all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. BUILDING _____ B. WING _____	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE NASHVILLE, NC 27856

(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 757	Continued From page 3 A review of the most recent Minimum Data Set (MDS) dated 8/31/18 coded as Quarterly Assessment, indicated the resident is cognitively intact with adequate vision and hearing. The MDS also indicated that Resident #33 exhibited no behaviors and no rejection of care. A review of the physicians' orders dated 1/31/18 revealed an order was written for Zyrtec (Cetirizine) 10mg once a day for complaints of throat irritation. Further review of the medical record revealed there were no physician orders to discontinue Zyrtec for complaints of throat irritation. A review of the physicians' orders revealed an order was written on 7/11/18 for Zyrtec (Cetirizine) 10mg once a day for post nasal drip. A review of the Medication Administration Records (MAR) for January 2018 - October 2018 revealed Resident #33 received Zyrtec (Cetirizine)10mg daily at 09:00 AM beginning 1/31/18 through 10/10/18. Further review revealed Resident #33 received Zyrtec (Cetirizine) 10mg once a day at 09:00 PM for post nasal drip beginning 7/11/18 through 10/10/18. On 10/11/18 at 12:50 PM a phone interview was conducted with the consultant pharmacist who stated that the Zyrtec (Cetirizine) 10mg that was administered at 09:00 AM and 09:00 PM each day would be considered duplicate therapy and an excessive dose. He stated that the maximum daily dose recommended is 10mg per day. On 10/11/18 at 02:54 PM an interview with the Director of Nursing (DON) was conducted. She	F 757	resident orders have been reviewed to identify any other duplicate orders. No other duplicate orders are currently in place. Licensed Nurses have been reeducated to review the medications that they are giving to ensure there is no duplication prior to administration. They have also been reeducated to review current orders when receiving new orders to notify the physician of any duplication caused by the new order. All education was completed on 10/30/18. New orders will be reviewed in the next morning clinical meeting after an order is written. This review will include reviewing all the resident orders to identify any duplication. Starting on 10/26/18, this review will be documented by the Director of Nursing or designee during each clinical meeting for 1 week, 3 clinical meetings a week for 4 weeks, and then 1 clinical meeting for 8 weeks. The Director of Nursing will report the findings of the monitoring to the monthly QA committee meeting for review and recommendations for the duration of the monitoring period. We allege compliance on 11/2/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. BUILDING _____ B. WING _____	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE NASHVILLE, NC 27856

(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 757	Continued From page 4	F 757		

stated that she was not aware of the duplicate order and that she would complete a record review of the residents MAR. She stated the nurses entering the orders should have caught the discrepancy. She stated she will in-service the nurses regarding transcribing orders.

On 10/11/18 at 3:00 PM an interview with the Administrator was conducted. He stated that it's his expectation that the nurses are transcribing orders appropriately and monitoring for duplicate orders.

2. Resident #21 was admitted to the facility on 4/18/2018 with diagnoses that included: chronic obstructive pulmonary disease, aphasia, dysphagia, hypertension, diabetes type II, gastro-esophageal reflux disease, dementia without behavior disturbance, pneumonitis due to inhalation of food and vomit.
A review was of the most recent Minimal Data Set (MDS) dated 7/26/2018, coded as Quarterly Assessment indicated the resident has unclear speech and is unable to make her needs known. The resident was coded as being cognitively impaired.
A review of the physicians' orders dated 4/19/2018 revealed an order for Nexium 20 mg once a day for gastro-esophageal reflux disease (GERD).
On 9/29/2018 Omeprazole 20 mg once a day was ordered once a day for gastro-esophageal reflux disease.
Further review of the medical record revealed there were no orders to discontinue the Nexium or the Omeprazole.
A review of the Medication Administration Records (MAR) for October 2018 revealed resident #21 received both Nexium and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. BUILDING _____ B. WING _____	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE NASHVILLE, NC 27856

(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 757	Continued From page 5	F 757		

Omeprazole at 8:00 am starting on October 1, 2018 through October 10,2018.
On 10/10/2018 at 2:00 pm a phone interview was conducted with the physician regarding duplicate medications (Nexium and Omeprazole). The physician stated that the resident should not be on both medications.
During an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 10/10/18 at 02:16 PM, She stated that she was not aware of the duplicate order. She also stated that once the medication is entered into the computer, the new order is sent to the pharmacy, where the pharmacist should be checking all new orders against the current medications. The DON also stated that the resident's physician signs each MAR at the beginning of the month. She also stated that she would be complete a record review of the residents MAR.
On 10/11/2018 at 10:31 am a phone interview was conducted with the pharmacist. He stated that he does medication reviews on each resident monthly. The last time he reviewed the resident's chart was on 9/14/2018 and the Omeprazole was started on 9/29/2018. He also stated if there is a medication duplication, he makes a recommendation to the physician, talks with the DON and if needed he calls the physician and he documents these conversation in the progress notes.
In an interview with the administrator on 10/11/18 01:23 PM, he stated his expectations from the pharmacist are: to look at medications carts, look for expired medications and perform a medication chart review. The administrator expects the pharmacy to the medication error before sending the medication to the facility. He also stated that when there is a medication duplication he expects

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. BUILDING _____ B. WING _____	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE NASHVILLE, NC 27856

(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 757	Continued From page 6 the nurses to question and clarify the order.	F 757		
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; §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	F 880		11/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. BUILDING _____ B. WING _____	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE NASHVILLE, NC 27856

(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 7 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. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to clean a glucometer (blood glucose meter used for blood sugar monitoring) after performing a finger stick blood sugar (FSBS) and according to the manufacturers recommendations for 1 of 1 residents. (Resident #33).	F 880	The glucometer for Resident #31 has been effectively cleaned and disinfected per labeled instructions. Resident with glucometers are at risk for this issue. Resident glucometers have all been effectively cleaned and disinfected per label instructions Licensed Nurses have been reeducated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. BUILDING _____ B. WING _____	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE NASHVILLE, NC 27856

(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 8 Findings included: A review of the facility policy for glucometer cleaning and disinfecting dated May 2016 indicated (in part) the glucometer should be cleaned after each use by wiping the surface with a germicidal towelette for two-three minutes per label instructions. A review of the manufacturers package instructions indicated the glucometer should be cleaned and disinfected using two towelettes, one for cleaning and a second wipe for disinfecting for one minute and allowing the exteriors to remain wet for the corresponding contact time (1 minute) for each disinfectant. Resident #33 was admitted to the facility on 2/23/15 with active diagnoses that included; Abnormal Posture, Hypothyroidism, Diabetes, Anemia, Depression, Hypertension, Reflux, Irritable Bowel Syndrome, and Left-Hand Contractures. A review of the most recent Minimum Data Set (MDS) dated 8/31/18 coded as Quarterly Assessment, indicated the resident is cognitively intact with adequate vision and hearing. The MDS also indicated that Resident #33 exhibited no behaviors and no rejection of care. A review of the physician's order dated 10/19/16, documents an order for Finger Stick Blood Sugars (FSBS) three times daily for Diabetes. On 10/10/18 at 05:30 AM during an observation, Nurse #2 was observed performing a FSBS on Resident #33. After obtaining the blood sugar the	F 880	as to the cleaning and disinfection of glucometers per label instructions and all education was completed on 10/30/18. Current Licensed Nurses will be observed cleaning and disinfecting glucometers per labeled instructions to verify the efficacy of the education. Random observation will be made during the use of glucometers for further verification. Starting on 10/22/18, these random observations will be documented by the Director of Nursing or designee daily for 5 days, starting on 10/27/18, 3 days a week for 3 weeks, and then weekly for 8 weeks. The Director of Nursing will report the findings of the monitoring to the monthly QA committee meeting for review and recommendations for the duration of the monitoring period. We allege compliance on 11/2/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. BUILDING _____ B. WING _____	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE NASHVILLE, NC 27856

(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 9	F 880		

nurse placed the glucometer back into the plastic case without cleaning the meter. Nurse #2 then left the residents room and returned to the medication cart. Nurse #2 was asked if she was going to clean the glucometer, then the nurse returned to the resident's room, cleaned the glucometer using one Super-Sani Wipe for approximately 30 seconds and placed the glucometer back in the plastic container.

On 10/10/18 at 06:30 AM an interview was conducted with Nurse #2, she stated that she thought the facility policy for cleaning glucometers was to clean for a minute or two. When asked where the policy was located, she stated it was kept in a book, but was unable to state where the book was kept.

On 10/10/18 at 11:00 AM an interview with the Director of Nursing (DON) was conducted. She stated that the facility uses the Super Sani wipes which have a 2-minute contact time. She stated the policy was located online through the corporate website, where all policies are kept. She stated that the nurses have been in serviced recently on cleaning and disinfecting glucometers, and that they are aware that the policies are found online. She stated that it is her expectation that all nurses are cleaning glucometers according to the policy. She stated she will be in servicing on glucometer cleaning again soon.

On 10/11/18 at 02:54 PM an interview was conducted with the facility Administrator, who stated that it was his expectation that the nurses cleaned the glucometers according to the policy. He stated he would address this concern with the staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. BUILDING _____ B. WING _____	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	**1210 EASTERN AVENUE NASHVILLE, NC 27856**

(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