STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 10/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/HERTFORD	1300 DON JUAN ROAD HERTFORD, NC 27944

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E 000	Initial Comments An unannounced recertification survey was conducted on 10/17/21 through 10/26/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID 7CJI11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/17/21 through 10/26/21. Event ID# 7CJI11 1 of the 3 complaint allegations was substantiated resulting in deficiency. Immediate Jeopardy was identified at: CFR 483.70 at tag F835 at a scope and severity (K) CFR 483.80 at tag F880 at a scope and severity (K) Immediate Jeopardy began on 10/19/21 and was removed on 10/22/21.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		11/17/21

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

Electronically Signed 11/19/2021

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F 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interviews the facility failed to maintain dignity of residents by failing to knock on doors or ask permission to enter resident rooms for 5 of 15 residents observed (Resident #2, Resident #31, Resident #7, Resident #20, and Resident #17). Findings included:	F 550	F 550 What corrective action will be accomplished for those residents found to have be affected by the deficient practice: Element #1 Per the 2567, on 10/17/2021, NA #3 was observed entering 3 separate resident	

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F 550	Continued From page 2 1. Resident #2 was admitted to the facility on 5/14/20. Resident #2's most recent quarterly minimum data set assessment dated 10/15/21 revealed he was significantly cognitively impaired. During an observation on 10/17/21 at 11:55 AM NA#3 entered Resident #2' s room without knocking to deliver his lunch tray. During an interview on 10/17/21 at 12:42 PM NA #3 stated she did not knock or ask permission to enter. She stated she was aware she should do so and could not articulate why she did not. During an interview with the Director of Nursing on 10/20/21 at 9:47 AM who stated staff should knock or announce themselves when entering a resident's room. An interview was conducted with the Assistant Director of Nursing on 10/20/21 at 10:52 AM and she stated that staff should always knock and introduce themselves when entering a resident's room. An interview was conducted with Resident #2 on 10/20/21 at 2:22 PM who stated he wanted staff to knock prior to entering his room. He stated he did not like it when staff just walked into his room and felt disrespected. During an interview with the Administrator on 10/20/21 at 3:38 PM he stated staff have been trained on resident rights and dignity. He stated NA #3 should have knocked and announced herself prior to entering a resident's room.	F 550	rooms during lunch tray pass; resident #32, resident # 26, and resident #33; and did not knock or wait prior to entering the resident room. Upon identification of NA #1 entering resident rooms prior to knocking and waiting, NA #1 was sought out and determined to not be in the facility or reachable. The decision was made to take this agency aide off the schedule due to concerns of non compliance moving forward The Agency scheduler was notified of the concern and need for education over resident dignity specific to knocking on doors and waiting for communication. No adverse outcomes were identified. How the facility will identify other residents having potential to be affected by the same deficient practice. Element #2 All residents have the potential to be affected by the deficient practice. No residents were found to be adversely affected by this deficient practice. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Element #3 Education was done by the Director of Nursing or Designee on Resident rights to include knocking on resident room doors with announcement of themselves prior to entrance into a resident□s room. This	

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F 550	Continued From page 3 2. Resident #31was admitted to the facility on 3/17/21. Resident #31's most recent quarterly minimum data set assessment dated 9/17/21 revealed he was significantly cognitively impaired. During an observation on 10/17/21 at 11:55 AM NA#3 entered Resident #31's room without knocking to deliver his lunch tray. During an interview on 10/17/21 at 12:42 PM NA #3 stated she did not knock or ask permission to enter Resident #31's room. She stated she was aware she should do so and could not articulate why she did not. During an interview with the Director of Nursing on 10/20/21 at 9:47 AM who stated staff should knock or announce themselves when entering a resident's room. An interview was conducted with the Assistant Director of Nursing on 10/20/21 at 10:52 AM and she stated that staff should always knock and introduce themselves when entering a resident's room. During an interview with Resident #31 on 10/20/21 at 1:52 PM he stated staff should knock or announce themselves prior to entering his room. During an interview with the Administrator on 10/20/21 at 3:38 PM he stated staff have been trained on resident rights and dignity. He stated NA #3 should have knocked and announced herself prior to entering a resident's room.	F 550	education was started on 10/22/21 and follow up education completed by 11/17/21 for all staff. This education will be implemented as part of orientation for new employees including new agency staff by the Director of Nursing or designee. How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: Element #4 To ensure ongoing compliance, the Director of Nursing and/or designee will conduct compliance audits weekly x 12 weeks to ensure staff are knocking on resident doors and waiting to enter prior to entering a resident room. The facility will provide education on any areas of concern. The results of the audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved x 3 months.	

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F 550	Continued From page 4	F 550		

3. Resident #7 was admitted to the facility on 7/30/21.

Resident #7's most recent minimum data set assessment, an admission assessment dated 10/15/21 revealed he was cognitively intact.

During an observation on 10/17/21 at 11:57 AM NA#3 entered Resident #7's room without knocking to deliver his lunch tray.

During an interview on 10/17/21 at 12:42 PM NA #3 stated she did not knock or ask permission to enter. She stated she was aware she should do so and could not articulate why she did not.

During an interview with the Director of Nursing on 10/20/21 at 9:47 AM who stated staff should knock or announce themselves when entering a resident's room.

An interview was conducted with the Assistant Director of Nursing on 10/20/21 at 10:52 AM and she stated that staff should always knock and introduce themselves when entering a resident's room.

During an interview with the Administrator on 10/20/21 at 3:38 PM he stated staff have been trained on resident rights and dignity. He stated NA #3 should have knocked and announced herself prior to entering a resident's room.

Attempts to interview Resident #7 were unsuccessful

4. Resident #20 was admitted to the facility on 7/2/12.

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F 550	Continued From page 5	F 550		

Resident #20's most recent quarterly minimum data set assessment dated 9/1/21 revealed he was significantly cognitively impaired. He was assessed as not being interviewable.

During an observation on 10/17/21 at 11:55 AM NA#3 entered Resident #31's room without knocking to deliver his lunch tray.

During an interview on 10/17/21 at 12:42 PM NA #3 stated she did not knock or ask permission to enter Resident #31's room. She stated she was aware she should do so and could not articulate why she did not.

During an interview with the Director of Nursing on 10/20/21 at 9:47 AM who stated staff should knock or announce themselves when entering a resident's room.

An interview was conducted with the Assistant Director of Nursing on 10/20/21 at 10:52 AM and she stated that staff should always knock and introduce themselves when entering a resident's room.

During an interview with the Administrator on 10/20/21 at 3:38 PM he stated staff have been trained on resident rights and dignity. He stated NA #3 should have knocked and announced herself prior to entering a resident's room.

5. Resident #17 was admitted to the facility on 5/30/13.

Resident #17's most recent quarterly minimum data set assessment dated 9/1/21 revealed she was moderately cognitively impaired.

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F 550	Continued From page 6 During an observation on 10/17/21 at 11:55 AM NA#3 entered Resident #31's room without knocking to deliver his lunch tray. During an interview on 10/17/21 at 12:42 PM NA #3 stated she did not knock or ask permission to enter Resident #17's room. She stated she was aware she should do so and could not articulate why she did not. During an interview with the Director of Nursing on 10/20/21 at 9:47 AM who stated staff should knock or announce themselves when entering a resident's room. An interview was conducted with the Assistant Director of Nursing on 10/20/21 at 10:52 AM and she stated that staff should always knock and introduce themselves when entering a resident's room. During an interview with the Administrator on 10/20/21 at 3:38 PM he stated staff have been trained on resident rights and dignity. He stated NA #3 should have knocked and announced herself prior to entering a resident's room. Attempts to interview Resident #17 were unsuccessful.	F 550		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in	F 582		11/17/21

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F 582	Continued From page 7	F 582		

nursing facility services under the State plan and for which the resident may not be charged;
(B) 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
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) 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/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due

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F 582	Continued From page 8 the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide an acknowledged Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) (form 10055) for 2 of 3 residents reviewed for beneficiary notification protection review (Resident #3 and Resident #16). The findings included: 1. Resident #3 was admitted to the facility on 5/21/14 with diagnoses including hypertension. He was admitted to Medicare Part A skilled services on 7/14/21. Resident #3's significant change Minimum Data Set assessment dated 7/18/21 revealed she was cognitively intact. Resident #3's Medicare Part A skilled services ended on 8/4/21. He remained in the facility. The SNF ABN reviewed had Resident #43's name, the date services were to end, and a statement that resident was made aware of non-coverage on 8/2/21. There were no options checked for the decision made about continuing Medicare Part A services on the notice.	F 582	F 582 Medicaid/Medicare Coverage/Liability Notice What corrective action will be accomplished for those residents found to have be affected by the deficient practice: Element #1 The facility failed to provide an acknowledged Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary (SNF ABN) for resident #3 and #16. Resident #3 # 16 were notified of the by the Social Worker and both residents/RPs Acknowledged they understood the end of Medicare Part A coverage and had no concerns. How the facility will identify other residents having potential to be affected by the same deficient practice. Element #2 Any residents receiving Medicare Part A services has the potential to be affected by this concern. All current residents and discharged residents who had a part A stayed since October 1, 2021, with an ABN required have been audited for	

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F 582	Continued From page 9 An interview was conducted with Social Worker #1 on 10/19/21 at 1:13 PM. She stated there should be an option checked for the decision made about continuing Medicare Part A services. The Social Worker stated she reviewed options with the resident but failed to ensure an option for continuing services was checked by Resident #3. She stated that there should have been documentation on the form about the discussion. An interview was conducted with Resident #3 on 10/20/21 at 1:52 PM who stated he did not remember signing the SNF-ABN An interview with the Administrator was conducted 10/20/21 at 3:38 PM who stated the social worker should have ensured the SNF-ABN form had been completed accurately by Resident #3. 2. Resident #16 was admitted to the facility on 10/31/18 with diagnoses including dementia. She was admitted to Medicare Part A skilled services on 5/13/21. Resident #16's quarterly Minimum Data Set assessment dated 8/20/21 revealed she was cognitively intact. Resident #16's Medicare Part A skilled services ended on 5/31/21. Record review revealed Resident #16's SNF-ABN was reviewed over the phone with her representative on 5/28/21. The SNF ABN reviewed had Resident #78's name and the date services were to end. There were no options checked for the decision made regarding continuing Medicare Part A skilled services.	F 582	completeness of the ABN form. Any problems identified will be reviewed with the resident/RP and concerns addressed if indicated. The Business Office Manager and Social Services Director were in-serviced on completing ABN□s completely by the Administrator on 10/25/21. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Element #3 Any current resident whose Medicare benefit has ended since September 1 was audited to ensure the resident had acknowledged the notification. This audit was completed on 11/17/21 by the Social Worker and Business Office Manager. The Administrator will track all Part A service days for residents with Medicare services in place. The Administrator will monitor the completion of the ABN□s for residents and receive a copy of all completed ABN□s. Additional education has been provided to the Business Office Manager and Social Services Director by the District Director, Business Office Services on 11/16/21. How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: Element #4	

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F 582	Continued From page 10 An interview was conducted with Social Worker #1 on 10/19/21 at 1:13 PM. She stated there should have been an option checked for the decision made about continuing Medicare Part A services for Resident #16. She stated she spoke with Resident #15's resident representative on 5/28/21 about Medicare Part A services ending and appeal rights. She stated there should have been documentation on the form about the discussion. An interview with the Administrator was conducted 10/20/21 at 3:38 PM who stated the SNF-ABN form should have been completed for Resident #16.	F 582	To ensure ongoing compliance, the Administrator will do compliance audits weekly x 12 weeks to ensure the Medicare SNF ABN process is completed accurately when a residents Medicare benefit is ending. The facility will provide education on any areas of concern. The results of the audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved x 3 months.	
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure a resident was referred to an outpatient nephrologist as indicated in the hospital discharge instructions for 1 of 1 sampled resident reviewed for medically related social services (Resident # 7). The findings included: Resident #7 was admitted to the facility on 7/30/21 with diagnoses that included chronic kidney disease.	F 745	F 745 What corrective action will be accomplished for those residents found to have be affected by the deficient practice: Element #1 Resident #7 did not have an outpatient nephrologist appointment scheduled as recommended by the discharge summary dated 7/30/21. The attending physician was informed of this on 10/20/21 and	11/17/21

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F 745	Continued From page 11 Resident #7's hospital discharge summary dated 7/30/21 read in part, "Patient will need referral/follow up with an outpatient nephrology provider to continue to help manage his CKD3 (chronic kidney disease) and chronic metabolic acidosis from ileal conduit (a system of urinary drainage created after bladder removal) requiring supplemental sodium bicarbonate." This refers to the secretion of sodium and bicarbonate due urine having contact with the bowel wall. Resident #7's most recent Minimum Data Set (MDS) assessment, dated 8/6/21, indicated the resident was cognitively intact. Resident #7 required extensive assistance with most activities of daily living including transfer, toileting, dressing and personal hygiene. A review of Resident #7's medical record revealed no appointments scheduled with nephrology since his admission. During an interview with the facility's Assistant Director of Nursing on 10/20/21 at 8:55 AM, she stated that she was unable to locate documentation of an appointment for Resident #7 during the period from July 2021 to present with nephrology. She indicated the nurse who admitted Resident #7 should have made this appointment. The nurse who admitted Resident #7 was unavailable for interview. An interview was conducted with the Director of Nursing (DON) on 10/20/21 at 9:03 AM. She stated Resident #7 should have had an appointment scheduled with a nephrologist. The DON stated it was her expectation when a nurse	F 745	indicated that there had been no harm as a result of the appointment not being scheduled. The resident and RP were notified of the missed appointment on 10/20/21. The Nephrology appointment was rescheduled for resident # 7 and was transported to the appointment on 11/10/21. How the facility will identify other residents having potential to be affected by the same deficient practice. Element #2 All residents admitted to the facility have the potential for a scheduled appointment from their hospitalization to be missed. All residents admitted since July 1st were audited for missed appointments indicated in hospital Discharge orders. No other concerns were identified. The audit was completed on 11/17/21 by the DON. Administrative nursing team members responsible for completing or reviewing the admission process and the transportation/appointment aide were in-serviced on 10/25/21 over identifying, scheduling and communicating appointments as indicated by hospital discharge paperwork. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Element #3 The discharge summaries were reviewed for all admits/readmits since July1, 2021	

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F 745	Continued From page 12 admits a resident all referral appointments are made. An interview was conducted on 10/20/21 at 11:15 AM with Resident #7's primary care physician. He indicated Resident #7 should have followed up with an outpatient nephrologist as stated in the hospital discharge summary. The physician stated Resident #7 had suffered no harm as a result of the lack of follow-up. An interview was conducted with the Administrator on 10/20/21 at 3:38 PM who indicated Resident #7 should have been referred to a nephrologist as stated in the hospital discharge summary.	F 745	by the Director of Nursing or the Director of nursing to ensure any referenced necessary appointments have been scheduled. This audit was completed on 11/17/21. The current licensed nursing staff received education by the Director of Nursing or ADON regarding reading the discharge summaries with new admits/readmits to ensure any referenced necessary appointments are scheduled. This education was completed on 11/17/21. This education will be part of new nurses and agency nurse□s orientation. How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: Element #4 To ensure ongoing compliance, the Director of Nursing and/or designee will review all new admit/readmit discharge summaries to ensure that any referenced necessary appointments have been scheduled. These audits will be conducted once a week x 12 weeks. The results of the audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved x 3 months.	
F 835 SS=K	Administration CFR(s): 483.70	F 835		11/17/21

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F 835	Continued From page 13 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to implement effective systems for administration to ensure that all staff were educated and competent to clean and disinfect a shared glucometer for 2 of 2 medication aides observed to perform fingerstick blood glucose tests with the use of a shared glucometer (Med Aide #1 and Med Aide #2). Immediate Jeopardy began on 10/19/21 when administration did not ensure effective protocols or systems were in place to ensure medication aides were educated and competent to clean and disinfect a shared glucometer. This was evident for 2 of 2 medication aides observed to perform fingerstick blood glucose tests (Med Aide #1 and Med Aide #2). There was no protocol in place to ensure this training and competency and there was not a protocol in place to orient new medication aides. The facility was not able to show that a skills checklist was completed for the 2 medication aides. Immediate Jeopardy was removed on 10/22/21 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of E (No actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure the monitoring of systems put into place and to complete facility	F 835	F 835 Administration What corrective action will be accomplished for those residents found to have be affected by the deficient practice: Element #1 The facility failed to implement effective systems for administration to ensure that the staff assigned to perform Fingerstick blood sugars were educated and competent as Certified Medication aides (#1 and #2), failed to disinfect a shared glucometer according to manufacturer□s instructions when used for multiple residents. Resident # 15,2,50,38 and 1 have not had an identified outcome related to this. Med Aide #1 and #2 were observed not disinfecting the glucometer in between residents on 10/19/21. They received education by the Director of Nursing related to cleaning and disinfecting glucometers with a required return demonstration on 10/19/21. How the facility will identify other residents having potential to be affected by the same deficient practice. Element #2 All residents that receive Fingerstick blood	

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F 835	Continued From page 14 employee and agency staff in-service orientation and training. The findings included: This tag is cross referenced to: F880 - Based on observations, staff interviews and record review the facility failed to use an approved procedure to clean and disinfect a shared glucometer used for 5 of 5 residents (Resident #15, #2, #50, #38 and #1). Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA) approved disinfectant in accordance with the manufacturer of the glucometer increased the likelihood of the spread of blood borne infections between residents. Failure to disinfect a shared glucometer was observed when 2 of 2 medication aides were observed to perform a fingerstick blood glucose test on residents and did not disinfect the glucometer per manufacturer ' s specifications (Med Aide #1 and Med Aide #2). On 10/19/21 at 12:10 PM an interview was conducted with the Assistant Director of Nursing (ADON) who was also the Infection Control Nurse in the facility. The ADON stated she was also was responsible for staff training in the facility. The ADON stated that Med Aide #1 had recently received her certification and had just started working as a med aide. The ADON further stated that Med Aide #1 received orientation on the medication (med) cart for 2-3 days with a nurse until the Med Aide was comfortable. The ADON stated that Med Aide #2 was from an agency and was expected to be able to go straight to the med	F 835	sugars are at risk if staff that perform the procedure are not trained and competent to perform the Fingerstick blood sugar. No resident has had an identified outcome related to this. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Element #3 The District Director of Clinical Services educated the administrative team, Administrator, DON, ADON and Unit Manager, over the Infection Control Manual Glucometer Decontamination policy and procedures for the use of finger stick blood glucose checks and the management of glucometers and cleaning requirements. This was completed on 10/20/2021. The Infection Control Manual Glucometer Decontamination policy was revised on 10/20/21 to reflect individual use glucometers will be used for each resident versus shared glucometers. The use of shared glucometers has been removed from our policy. On 10/20/21, the Administrator, Director of Nursing and Assistant Director of Nursing worked with the District Director of Clinical Services and the county Health Department nurse to review the policy and procedure for the use of glucometers with residents, reviewed the manufacturer s recommendations for cleaning and disinfecting, and developed a plan of action and an education tool for training nurses and certified Medication aides over the facility s corrective action plan and over the proper management of the residents individual glucometer.	

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F 835	Continued From page 15 cart and do the job. The ADON further stated that agency staff received some general orientation to the facility but did not receive training related to medications or the glucometer. On 10/20/21 at 1:20 PM the ADON stated in an interview that Med Aide #1 started working as a Med Aide in the facility on 9/23/21 and had worked under the guidance of Nurse #1. The ADON further stated there was not a training protocol in place for the nurse that trained the Med Aide. The ADON stated Med Aide #1 had worked on the med cart most of the time she worked and would frequently use the glucometer during her shift. The ADON stated that Med Aide #2 had worked in the facility for at least several months and always worked on the med cart and would frequently use a glucometer during her shift to check a fingerstick blood glucose for the residents on her assigned hall. The ADON further stated that Med Aide #1 worked the 7 AM to 7 PM shift and Med Aide #2 worked mostly 7 AM to 7 PM but had worked some 7 PM to 7 AM shifts. On 10/21/21 at 2:20 PM an interview was conducted with Nurse #1 who stated she worked on the med cart with Med Aide #1 for 1-2 days. The Nurse further stated she did not have a protocol for this orientation and discussed things that came up during medication pass. The Nurse stated if they had a fingerstick blood glucose to do they did that. The Nurse stated she would physically wipe the glucometer for 3-5 minutes, then let it air dry. The Nurse further stated she observed Med Aide #1 to clean and disinfect the glucometer for 3-5 minutes while they were talking about other things related to the med pass but did not time her.	F 835	The administrative corrective plan of action is to ensure that each resident that has a blood sugar glucose has been given an individually assigned glucometer. This was implemented by placing individual glucometers at each resident□s bedside as of 10/19/21 by the Director of Nursing (DON) and this has continued since that time. The previously shared glucometers were removed from the med carts. Extra Glucometers are available for staff that do the finger stick blood sugar (FSBS) to ensure new admissions or residents with new orders for FSBS□s have their own glucometer. Current medication aides and licensed nurses received training initiated on 10/19/21 by the DON or ADON on the policy change that all residents will have an individually assigned glucometer. The training included the importance of cleaning and disinfecting the glucometer per manufactures guidelines, that the facility will use the micro-kill germicidal bleach wipes for cleaning, and that the contact time required is 3 minutes when cleaning. The education included the purpose for following cleaning and disinfecting the glucometer is due to the likelihood of cross contamination and the spread of Blood Borne Pathogens among residents. This education was completed on 10/20/21 by the Director of Nursing and Assistant Director of Nursing. Effective 10/20/21; no medication aide or licensed nurse will do a finger stick Blood sugar check without the validation of the blood glucose monitoring checklist has been completed. This will include agency	

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F 835	Continued From page 16 On 10/20/21 at 11:15 AM the Nurse Consultant stated they had education records from the agency for Med Aide #2, but they did not address the cleaning or disinfecting procedures for the glucometer. On 10/20/21 at 11:42 AM the ADON stated in an interview that Med Aide #1 trained with Nurse #1 for 2-3 days when she first started as a med aide. The ADON further stated she had no documentation that Med Aide #1 was trained on cleaning and disinfecting the glucometer. On 10/20/21 at 10:45 AM the Administrator was notified of the Immediate Jeopardy. The facility provided a credible allegation of Immediate Jeopardy removal on 10/21/21. The allegation of Immediate Jeopardy removal indicated: The problem identified was that licensed nurses and certified medication aides failed to use the appropriate procedure to clean and disinfect a shared glucometer used for five residents (#15, #2, #50, #38 and #1), required to have a blood sugar glucose. The facility Certified Medication Aides (#1 and #2) were observed not disinfecting the glucometer in between residents on 10/19/21. The administration team did not have adequate evidence of education and training provided prior to staff performing the task. Every resident that receives a fingerstick blood sugar check is at risk. The facility administration team, including the Administrator, Director of Nurses, Assistant Director of Nurses and Unit Manager failed to implement effective policy and procedure for the	F 835	and new staff as part of orientation. How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: Element #4 To ensure ongoing compliance, the Director of Nursing or Assistant director of nursing will conduct random audits for 12 weeks to observe staff while doing glucometer checks . This will include observations to verify glucometers are not shared and that they are cleaned and disinfected per the manufactured guidelines. The results of the audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved x 3 months. The facility alleges removal of immediate jeopardy 10/22/21 The QA-QAPI Committee met on 11/17/21 and reviewed the findings of the immediate jeopardy sited on 10/19/21. The Plan of Correction was accepted by the QA-QAPI committee.	

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use of fingerstick blood glucose checks and failed to educate the licensed nurses and certified medication aides of these policies and procedures. The administration failed to ensure training was provided before tasks were assigned and failed to have a process in place to train new staff or agency staff over these policy and procedures for blood glucose management. The Medical Director was made aware and agreed with the steps taken as indicated in our plan of correction.

The District Director of Clinical Services educated the administrative team, Administrator, DON, ADON and Unit Manager, over the Infection Control Manual-Glucometer Decontamination policy and procedures for the use of fingerstick blood glucose checks and the management of glucometers and cleaning requirements. This was completed on 10/20/21. The Infection Control Manual-Glucometer Decontamination policy was revised on 10/20/21 to reflect individual use glucometers will be used for each resident versus shared glucometers. The use of shared glucometers has been removed from our policy.

On 10/20/21 the Administrator, Director of Nursing and the Assistant Director of Nursing worked with the District Director of Clinical Services and the county Health Department nurse to review the policy and procedure for the use of glucometers with residents, reviewed the manufacturer ' s recommendations for cleaning and disinfecting and developed a plan of action and an education tool for training nurses and certified medication aides over the facility ' s corrective action plan and over the proper management of the residents ' individual glucometer. The administrative corrective plan of

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action ensured that each resident that has a blood sugar glucose has been given an individually assigned glucometer that has been placed at their bedside as of 10/19/21 by the Director of Nursing (DON). The previously shared glucometers were removed from the med carts. Extra glucometers are available for staff that do the fingerstick blood sugar (FSBS) to ensure new admissions or residents with new orders for FSBS have their own glucometer. This was completed on 10/20/21.

On 10/21/21, responsible parties (RP) for residents and those residents that receive fingerstick blood sugar checks have been notified by the Assistant Director of Nursing or Director of Nursing of the potential exposure of blood borne pathogens due to not properly disinfecting a shared glucometer. They were informed that we will be using individual glucometers for each resident. RPs and residents were informed that the local Health Department had been notified and we will be following any recommendations that they provide regarding the potential exposure to blood borne pathogens. The Health Department Nurse, on site 10/21/21, indicated that her recommendations would be completed and provided to the facility in approximately 1 week. The Administrator indicated to the Health Department Nurse that the facility would follow the Health Department recommendations.

Current medication aides and licensed nurses have received training by the DON or ADON on the importance of cleaning and disinfecting the glucometer per manufacturer ' s guidelines using the blood glucose monitoring cleaning checklist. The training/education checklist covers the process of cleaning, it will include observation

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and return demonstration. This checklist indicates the facility will use the (name of) germicidal bleach wipes and the contact time required is 3 minutes. The education includes the purpose for following cleaning check list process for glucometers due to the likelihood of cross contamination and the spread of blood borne pathogens among residents. The education has been provided to all licensed nurses and certified medication aides regarding the procedure for cleaning and disinfecting glucometers, that they will continue to clean and disinfect the individually issued glucometers before and after use that are stored at the residents ' bedside. This education was completed on 10/20/21 by the Director of Nursing and the Assistant Director of Nursing. Effective 10/20/21, no medication aide or licensed nurse will do a fingerstick blood sugar check without the validation of the blood glucose monitoring checklist. This will include agency and new staff.

The Director of Nursing will be responsible to ensure licensed nurses and certified medication aide staff are oriented and trained before performing the task of a fingerstick blood sugar check. Continued education will be performed by the DON, ADON or Unit Manager for any new facility nurses of certified med aides and agency staff before the fingerstick blood glucose checks are done. The training/education checklist covers the process of cleaning and will include observation and return demonstration. This checklist indicates the facility will use the (name of) germicidal bleach wipes and the contact time required is 3 minutes. The education includes the purpose for following cleaning check list process for glucometers due to the likelihood of cross contamination and the spread of blood borne

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pathogens among residents.
The facility alleges removal of Immediate Jeopardy 10/22/21.

On 10/26/21 from 10:00 AM to 12:45 PM, multiple staff members were interviewed. This included nurses and certified medication aides. All interviewed staff members validated they had attended in-service training regarding glucometers and infection control. Interviewed staff members were aware of the individual glucometers for each resident that required blood glucose checks. Staff stated each glucometer was stored in the resident ' s room with a supply of test strips. Three staff members were observed to perform blood glucose checks. Staff performed hand hygiene, cleaned the glucometer with a disinfecting wipe for the required amount of time and waited for the glucometer to air dry. After testing the resident ' s blood glucose, staff followed the same procedure to clean the glucometer. The glucometer was then returned to a storage case and stored in each resident ' s room. A resident who was cognitively intact reported the staff cleaned the glucometer prior to testing her blood glucose and again afterwards. The facility provided documentation of in-service training for the nurses and the med aides. The training/education checklist covered the process of cleaning and included observation and return demonstration. This checklist indicated the facility would use (name of) germicidal bleach wipes and the contact time required was 3 minutes. The education included the purpose for following the cleaning check list process for glucometers was due to the likelihood of cross contamination and the spread of blood borne pathogens among residents. The facility also had documented audits completed per their credible allegation of

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F 835	Continued From page 21 compliance. Staff from the local Health Department visited the facility on 10/21/21. During an interview with the Director of Nursing (DON) on 10/26/21 at 12:15 PM, the DON stated she had spoken with the local Health Department and they had no additional recommendations. She reported they had not received an official report from the Health Department. Review of the facility documentation revealed a policy that stated no staff would be allowed to perform blood glucose monitoring without the required training and a return demonstration. Training and return demonstration evidence for all licensed nurses and medication aides was reviewed. The facility ' s credible allegation was validated, and the Immediate Jeopardy was removed on 10/22/21.	F 835		
F 880 SS=K	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:	F 880		11/19/21

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F 880	Continued From page 22 §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 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	F 880		

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F 880	Continued From page 23 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, staff interviews and record review the facility failed to use an approved procedure to clean and disinfect a shared glucometer used for 5 of 5 residents (Resident #15, #2, #50, #38 and #1) reviewed for fingerstick blood glucose tests. Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA) approved disinfectant in accordance with the manufacturer of the glucometer increased the likelihood of the spread of blood borne infections between residents. Failure to disinfect a shared glucometer was observed when 2 of 2 medication aides were observed to perform a fingerstick blood glucose test on residents (Med Aide #1 and Med Aide #2). The facility also failed to ensure staff performed hand hygiene when passing trays to 8 of 8 resident rooms (Rooms #306, #204, #203, #210, #209, #212, #200, and #202). Immediate Jeopardy began on 10/19/21 when Med Aide #1 performed a fingerstick blood glucose test for a resident on her assigned hall using a shared glucometer and did not follow the	F 880	F 880 Infection Control What corrective action will be accomplished for those residents found to have be affected by the deficient practice: Element #1 on Glucometers The facility failed to use the appropriate procedure to clean and disinfect a shared glucometer used for five residents, #15, #2, #50, #38 and #1, required to have a blood sugar glucose. An individual glucometer was provided for each resident on 10/19/21 by the Director of Nursing. The attending physician, the responsible party and the resident received notification about the risk of spread of blood borne pathogens related to the failure to appropriately disinfect the glucometer and that individualized glucometers had been issued. This notification was completed on 10/19/21 by ADON. No negative outcomes have been for the identified residents. Med Aide #1 and #2 were observed not disinfecting the glucometer in between residents on 10/19/21. They received	

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F 880	Continued From page 24 manufacturer ' s instructions to disinfect the glucometer between residents. Immediate Jeopardy was removed on 10/22/21 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of E (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training. Example #2 was cited at a scope and severity of D. The findings included: Review of the facility policy titled Glucometer Decontamination dated 02/18 listed the purpose of the policy was to implement a safe and effective process for decontaminating glucometers after use on each resident. The policy statement read: "In the event that glucometers are shared within a facility, the glucometer shall be decontaminated with the facility approved wipes following use on each resident. II Cleaning and disinfecting the glucometer: E. Wipe the monitor and ensure it is visibly wet (May wrap glucometer with wipe in order to ensure wet for entire time instructed. G. Allow the monitor to air dry." The manufacturer instructions for the glucometer used by the facility instructed the disinfection procedure as follows: "To disinfect your meter, clean the meter with one of the validated disinfecting wipes listed below." The disinfecting wipe used by the facility was included in the manufacturer ' s list. "Wipe all external areas of the meter including both front and back surfaces until visibly clean. Allow the surface of the meter	F 880	education by the Director of Nursing related to cleaning and disinfecting glucometers with a required return demonstration on 10/19/21. How the facility will identify other residents having potential to be affected by the same deficient practice. Element #1 on handwashing The facility failed to ensure staff performed hand hygiene when passing trays to residents in Room #306/204/203/210/209/221/200 and 202. No negative outcomes have been identified for these residents. How the facility will identify other residents having potential to be affected by the same deficient practice. Element #2 on glucometers All residents that receive blood sugar glucose checks are at risk . Element #2 on handwashing All residents are identified at risk if staff do not perform hand hygiene when indicated for infection control purposes to include passing of resident□s trays. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Element #3 on Glucometers Each resident that has a blood sugar glucose was given an individually assigned glucometer that has was placed at their bedside as of 10/19/21 by the Director of Nursing (DON). The previously shared glucometers were removed from the med carts. Extra Glucometers are available for staff that do the finger stick blood sugar (FSBS) to ensure new admissions or residents with	

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to remain wet at room temperature for the contact time listed on the wipe ' s directions for use. Wipe meter dry or allow to air dry."

The directions on the container of germicidal bleach wipes used by the facility read: "Apply pre-saturated towelette and wipe desired surface to be disinfected." The contact time listed on the container as the time required to kill all bacteria and viruses was 3 minutes.

The blood glucose monitor cleaning skills checklist provided by the facility read as follows: "6. Wipe the monitor thoroughly, ensuring it is visibly wet and place on a clean surface. 7. Follow the wipe manufacturer ' s instructions for the length of time the monitor must remain wet. Wrap the monitor with an additional wipe, if necessary, to ensure it remains wet for the required time. 8. Once the appropriate length of time has elapsed, allow the monitor to air dry on a clean surface."

1. On 10/19/21 at 11:40 AM, Med Aide #1 was observed to check a fingerstick blood glucose for Resident #15. The Med Aide was observed to return to the medication cart and used a germicidal bleach wipe and wiped the glucometer front and back for approximately three seconds, disposed of the wipe, dried the glucometer with a tissue, wrapped the glucometer in the tissue and placed it back on the medication cart. During the observation, Med Aide #1 stated that the residents did not have their own glucometer and the one she used, was shared between other residents. The Med Aide stated that at this time she had no further blood glucose checks.

A second interview was conducted with Med Aide

orders for FSBS□s have their own glucometer. The Director of Nursing completed another audit of all residents receiving blood sugar checks to ensure there was an individual glucometer at bedside and that the medication carts did not have any glucometers that were being shared on them on 10/25/21.
Current medication aides and licensed nurses received training on the importance of cleaning and disinfecting the glucometer per manufactures guidelines using the Blood glucose monitoring Cleaning checklist. The training/education checklist covered the process of cleaning, and included observation and return demonstration. This checklist indicates the facility will use the micro-kill germicidal bleach wipes and the contact time required is 3 minutes. Education ensures that staff understand, even though the residents have their own glucometers, they still have to clean and disinfect them after every use according to the manufacturer□s instructions. The education includes the purpose for following cleaning check list process for glucometers due to the likelihood of cross contamination and the spread of Blood Borne Pathogens among residents. This education was started on 10/19/21 by the Director of Nursing and Assistant Director of Nursing. Effective 10/20/21 no medication aide or licensed nurse will do a finger stick Blood sugar check without the validation of the blood glucose monitoring checklist. This will include agency and new staff.
The Health Department Nurse did an

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F 880	Continued From page 26 #1 on 10/19/21 at 2:15 PM. The Med Aide stated she took a med aide class at a local college and they were taught to wipe off the glucometer before and after each resident. The Med Aide further stated the glucometer was supposed to be wet for 15-20 seconds and sit and dry for 3-5 minutes. On 10/19/21 at 4:00 PM, Med Aide #1 stated she knew how to clean the glucometer but was nervous when being observed to do the fingerstick blood glucose. A review of each resident ' s electronic medical record revealed the following: --In addition to the blood glucose level observed to be checked by Med Aide #1 on 10/19/21 at 11:40 AM, Resident #15 also had her blood glucose results documented by Med Aide #1 on 10/14/21 at 12 Noon and 4:00 PM. --In addition, Resident #2 had a blood glucose documented as checked by Med Aide #1 at 8:00 AM and prior to lunch on 10/19/21. A blood glucose was also documented for Resident #2 on 10/14/21 at 12 Noon and 4:00 PM by Med Aide #1. --In addition, Resident #50 had a blood glucose documented as checked by Med Aide #1 on 10/19/21 at 8:00 AM and on 10/14/21 at 12 Noon and 4:00 PM. On 10/19/21 at 12:10 PM the Assistant Director of Nursing (ADON) who was also the Infection Control Nurse stated in an interview that Med Aide #1 was oriented on the medication cart for 2-3 days by one of the nurses until the Med Aide	F 880	onsite visit on 10/21/21 and reviewed the residents Medical Records that received Finger stick blood sugars. The Health Department nurse agreed with the facilities systemic change not to share any glucometers and to use the manufacturers guidelines to clean and disinfect the glucometers. No additional recommendations were made. Element #3 on Handwashing Education was started on 10/22/21 for current staff relate to proper hand hygiene to include performing hand hygiene in between delivery of trays before each resident is served by the Director of nursing and Assistant Director of Nursing. This education was expanded, continued and completed on 11/16/21 for all nursing staff. This education will be part be part of orientation for new hires, contract staff, and agency staff. How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: Element #4 On Glucometer To ensure ongoing compliance, the Director of Nursing or Assistant director of nursing will conduct random audits for 12 weeks to observe staff while doing glucometer checks. This will include observations to verify glucometers are not shared and that they are cleaned and disinfected per the manufactured guidelines. The results of the audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved x 3 months. The QA-QAPI Committee met on 11/17/21 and	

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F 880	Continued From page 27 felt comfortable. The ADON stated the staff was to disinfect the glucometer before and after use because the glucometer was shared between residents. The ADON further stated the staff were to use the wipes to clean the glucometer and wait for 5 minutes to dry. On 10/19/21 at 2:00 PM the Administrator provided the date that Med Aide #1 started on the medication cart as being 9/23/21. The Nurse Consultant stated in an interview on 10/19/21 at 2:10 PM, that the glucometer was supposed to be disinfected with the bleach wipe and the contact time was the time listed on the bleach wipe container which was 3 minutes. The Nurse Consultant further stated the glucometer was shared between residents. The Nurse Consultant stated they would begin in-services immediately to educate the staff on the proper way to disinfect the glucometer. The Nurse Consultant stated they had ordered and received individual glucometers for residents that required fingerstick blood glucose tests. 2. On 10/19/21 at 11:48 AM, Med Aide #2 (agency) was observed to do a fingerstick blood glucose on Resident #38. The Med Aide was observed to return to the medication cart and removed an approved wipe and wiped the glucometer for approximately 5 seconds, disposed of the wipe and wrapped the glucometer in a tissue and placed in a drawer on the medication cart. On 10/19/21 at 2:15 PM Med Aide #2 stated in an interview she had been a Med Aide for 7 years and had worked for the agency for 1 year. The	F 880	reviewed the findings of the immediate jeopardy sited on 10/19/21, as per below. The Plan of Correction was accepted by the QA-QAPI committee. Element #4 on Handwashing To ensure ongoing compliance, the Director of Nursing or Assistant director of nursing will conduct random audits across all departments for 12 weeks to ensure proper infection control hand hygiene performance (to include hand hygiene when passing trays). The results of the audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved x 3 months. The QA-QAPI committee will be led by the Administrator and the Committee will review findings and make recommendations as needed. The QA-QAPI Committee met on 11/17/21 and reviewed the findings of the immediate jeopardy sited on 10/19/21, as per below. The Plan of Correction was accepted by the QA-QAPI committee. The Medical Director was informed by the District Director of Clinical services on 10/20/21 of the Immediate Jeopardy related to shared glucometers and the cleaning disinfecting procedures required per manufactures guidelines were not followed. The Medical Director was informed that the Health Department nurse would review the affected resident records to evaluate the risk for possible exposure for Blood Borne Pathogen cross contamination and need for follow up testing. The Medical Director was also informed that we are using individually	

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F 880	Continued From page 28 Med Aide further stated she did not receive training on how to clean a glucometer from the agency but in some of the buildings she had worked, she was told to wipe off the glucometer with the bleach wipe and it needed to be wet for 2-3 minutes. On 10/20/21 at 8:26 AM, Med Aide #2 stated in an interview she knew the glucometer needed to stay wet for 3 minutes, but she had medications to pass and she did not do it. --In addition to the blood glucose level checked on 10/19/21 at 11:48 AM, Med Aide #2 documented a blood glucose for Resident #1 on 10/19/21 prior to lunch. There was also a blood glucose documented on Resident #1 by Med Aide #2 on 10/1/21 and 10/6/21 at 11:30 AM and 4:30 PM. On 10/19/21 at 12:10 PM the Assistant Director of Nursing (ADON) stated in an interview that Med Aide #2 was an agency Med Aide that had worked in the facility for several months. The ADON stated the staff was to clean the glucometer before and after use because they were using a shared glucometer. The ADON further stated the staff were to use the wipes to clean the glucometer and wait for 5 minutes to dry. The Nurse Consultant stated in an interview on 10/19/21 at 2:10 PM that the glucometer was supposed to be disinfected with the bleach wipe and the contact time was the time listed on the bleach wipe container which was 3 minutes. The Nurse Consultant further stated the glucometer was shared between the residents. The Nurse Consultant stated they would begin in-services	F 880	assigned glucometers for residents as of 10/20/21; and, that education will be provided to all Licensed nurses and Certified Medication Aides regarding the procedure for cleaning and disinfecting glucometers, that they will continue to clean and disinfect the individually issued glucometers before and after use that are stored at the resident□s bedside. On 10/20/21, the nurse at the local Health Department was informed by the District Director of Clinical Services of on the Immediate Jeopardy related to shared glucometers and the cleaning disinfecting procedures required per manufactures guidelines were not followed. The Health Department nurse recommended to proceed with the issuance of individually assigned glucometers. She was informed that this had already been put in place. She did indicate she was going to speak to her supervisor and would give an update of any additional recommendations. She was informed of the conversation with the medical Director, and, that education will be provided to all Licensed nurses and Certified Medication Aides regarding the procedure for cleaning and disinfecting glucometers. The Health Department nurse was informed by the Administrator that the facility will follow any recommendations made by the Health Department nurse. Responsible parties of the affected residents have been notified as of 10/21/21 of the potential for exposure to blood borne pathogens through the use of shared blood glucose glucometers.	

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F 880	Continued From page 29 immediately to educate the staff on the proper way to disinfect the glucometer. The Nurse Consultant stated they had ordered and received individual glucometers for residents that required a fingerstick blood glucose test but had not yet put them in the resident ' s rooms to be used. On 10/20/21 at 10:45 AM, the Administrator was informed of the Immediate Jeopardy. The facility provided a credible allegation of Immediate Jeopardy removal on 10/21/21. The allegation of immediate jeopardy removal indicated: Credible Allegation of Immediate Jeopardy Removal: The facility failed to use the appropriate procedure to clean and disinfect shared glucometers used for 5 residents, #15, #2, #50, #38 and #1, required to have a blood sugar glucose. The facility failed to educate Med Aide #1 and Med Aide #2 on how to clean and disinfect a shared glucometer according to manufacturer ' s instructions when used for multiple residents. Med Aide #1 and #2 were observed not disinfecting the glucometer in between residents on 10/19/21. Each resident that has a blood sugar glucose has been given an, individually assigned glucometer that has been placed at their bedside as of 10/19/21 by the Director of Nursing (DON). The previously shared glucometers were removed from the medication carts. Extra glucometers are available for staff that do the fingerstick blood sugar (FSBS) to ensure new admissions or residents with orders for FSBS ' s have their own	F 880	The Health Department Nurse is on site as of 10/21/21 to evaluate the need for any testing for the affected residents. The Administrator has informed the Health Department nurse that her recommendations will be followed. The facility alleges removal of immediate jeopardy 10/22/21 11/17/21 and reviewed the findings of the immediate jeopardy sited on 10/19/21, as per below. The Plan of Correction was accepted by the QA-QAPI committee.	

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glucometer.

Current medication aides and licensed nurses will receive training on the importance of cleaning and disinfecting the glucometer per manufacture ' s guidelines using the Blood Glucose Monitoring/Cleaning checklist. This checklist indicates the facility will use the (name of) germicidal bleach wipes and the contact time required is 3 minutes. Education ensures that staff understand, even though the residents have their own glucometers, they still have to clean and disinfect them after every use according to the manufacturer ' s instructions.

The education includes the purpose for following cleaning check list process for glucometers due to the likelihood of cross contamination and the spread of blood borne pathogens among residents. This education was started on 10/19/21 by the Director of Nursing and the Assistant Director of Nursing. Effective 10/20/21 no medication aide or licensed nurse will do a fingerstick blood sugar check without the validation of the blood glucose monitoring checklist. This will include agency and new staff. The Director of Nursing will be responsible for keeping up the list of staff training completion of the blood glucose monitoring checklist.

The Medical Director was informed by the District Director of Clinical services on 10/20/21 of the Immediate Jeopardy related to shared glucometers and the cleaning/disinfecting procedures required per manufacturer ' s guidelines were not followed. The Medical Director was informed that the Health Department Nurse recommended to proceed with the issuance of individually assigned glucometers.

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She was informed that this had already been put in place. She did indicate she was going to speak to her supervisor and would give an update of any additional recommendations. She was informed of the conversation with the Medical Director and that education will be provided to all licensed nurses and certified medication aides regarding the procedure for cleaning and disinfecting glucometers. The Health Department Nurse was informed by the Administrator that the facility will follow any recommendations made by the Health Department Nurse.
Responsible parties of the affected residents have been notified as of 10/21/21 of the potential for exposure to blood borne pathogens through the use of shared blood glucose glucometers.

The Health Department Nurse is on site as of 10/21/21 to evaluate the need for any testing for the affected residents. The Administrator has informed the Health Department Nurse that her recommendations will be followed.

The facility alleges removal of Immediate Jeopardy on 10/22/21.

On 10/21/21 at 1:55 PM the Health Department Nurse stated in an interview that she had looked at every chart to see who got fingerstick blood sugar (FSBS) test and no one that had orders for a FSBS had hepatitis and there were no residents in the facility with a diagnosis of Human Immunodeficiency Virus (HIV) that required a fingerstick blood glucose. The Nurse further stated she would pass her findings on to the city branch who would make the recommendations. The Nurse stated it would take up to a week at the most for her to get the recommendations back to the facility, but it would probably not take

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that long.
On 10/26/21 from 10:00 AM to 12:45 PM multiple staff members were interviewed. This included nurses and medication aides. All interviewed staff members validated they had attended in-service training regarding glucometers and infection control. The interviewed staff members were aware of individual glucometers for each resident that required blood glucose checks. Staff stated the glucometer was stored in the resident ' s room in a case with a supply of test strips. Three staff members were observed to perform blood glucose checks. The staff performed hand hygiene, cleaned the glucometer the required amount of time and waited for the glucometer to air dry. After testing the resident ' s blood glucose, staff followed the same procedure to disinfect the glucometer. The glucometer was then returned to the storage case and stored in the resident ' s room. A resident who was cognitively intact reported staff cleaned her glucometer prior to testing her blood glucose and again afterwards. The facility provided documentation of in-service training for the nurses and medication aides. The training/education checklist covered the process of cleaning, observation and return demonstration. This checklist indicated the facility would use the (name of) germicidal bleach wipes and the contact time required was 3 minutes. The education included the purpose for following the cleaning check list process for glucometers was due to the likelihood of cross contamination and the spread of blood borne pathogens among residents. The facility also had documented evidence of audits completed per their credible allegation of compliance.

The facility ' s credible allegation of immediate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 10/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/HERTFORD	1300 DON JUAN ROAD HERTFORD, NC 27944

(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
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jeopardy removal was validated, and the Immediate Jeopardy was removed on 10/22/21.
2. During an observation of Nurse Aide (NA) #3 on 10/17/21 at 11:55 AM, she retrieved a meal tray from the food cart positioned in the middle of the resident hall, entered room #206 and set the food tray directly in front of the resident and uncovered the food. She then exited the room without washing her hands or using sanitizer. NA#3 returned to the food cart, retrieved another meal tray, entered room #204, placed the meal tray on the table beside the resident, and exited the room without performing hand hygiene. NA #3 returned to the food cart, retrieved another meal tray, entered rooms # 203, #209, #212, #200, and #202 and completed the same process without performing hand hygiene.

During an interview with NA #3 on 10/17/21 at 12:42 PM, she stated she did not perform hand hygiene prior to or upon exiting resident rooms to deliver meal trays. She stated she waited until after she passed all meal trays and then performed hand hygiene. NA #3 stated that it was not necessary to perform hand hygiene between residents.

During an interview with the Director of Nursing on 10/20/21 at 9:47 AM who stated staff are to perform hand hygiene before and after delivering each meal tray.

An interview was conducted with the Assistant Director of Nursing on 10/20/21 at 10:52 AM and she stated that she was responsible for the facility's infection control program. She explained staff were instructed to use hand sanitizer every time they went in a resident's room and to wash their hands after direct care. She

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F 880	Continued From page 34 stated NA #3 should have performed hygiene before and after delivering each meal tray. During an interview with the Administrator on 10/20/21 at 3:38 PM he stated staff have been trained to perform hand hygiene when passing meal trays and NA #3 should have performed hand hygiene when passing resident meal trays.	F 880		