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	255269	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS	F 000		

**Amended 2567 to correct the exit date of the survey to 4/29/21 to include the extended survey to obtain additional documentation and interviews.

The State Agency (SA) conducted an annual recertification survey along with complaint investigations MS #17603, MS #17393, MS #17028, MS #17167, MS #16746, and MS #16626 from 4/5/20 to 4/9/20. The SA re-entered the facility on 4/29/21 for an extened survey to obtain additional documentation and interviews. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA substantiated MS #16626 for failure to assess and failure to investigate, prevent, and correct alleged violation. The SA cited F609 and F610. The SA did not substantiate MS #16746 for Quality of Care and Infection Control, MS #17028 for staffing and Infection Control, MS #17167 for Abuse, MS #17393 for Quality of Care, Rehabilitation, and Accidents, and MS #17603 for Quality of Care, with no citations related to these complaints.

The SA indentified an Immediate Jeopardy (IJ) that began on 4/6/20, when the facility failed to use wipes appropriate for disinfecting a multi use bedside fingerstick glucometer for Resident #15, Resident #27, and Resident #122. The use of 75% alcohol wipes, instead of the manufacturer recommended disinfectant wipes, was likely to cause serious harm, injury, or death by causing the transmission of blood-borne pathogens to any resident receiving bedside fingerstick blood glucose testing.

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

Electronically Signed | 05/12/2021

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F 000	Continued From page 1 The facility's failure to ensure the multi resident use glucometer was cleaned and disinfected, prior to use and between residents, placed Residents #15, #27, and #122 and the other 32 residents who required the use of a glucometer to check blood sugar, in a situation that was likely to cause serious injury, harm, impairment, or death. The SA notified the Administrator on 4/7/21, at 9:20AM of the IJ and provided the IJ Template to the Administrator. . The Immediate Jeopardy existed at 42 CFR(s): 483.80 (a)(1)(2)(4)(e)(f)-Infection Prevention and Control (F880). The facility submitted an acceptable Removal Plan on 4/8/21, in which the facility alleged all corrective actions were completed by 4/8/21 and the IJ was removed on 4/9/21. The SA vaildated the Removal Plan on 4/9/21 and determined the IJ was removed 4/9/21, prior to exit, therefore the scope and severity for 42 CFR 483.80 was lowered from a "K" to a level "E", while the facilty developed a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The facility also cited deficiencies at F576, F677, F684, F760, F773, and F880. The facility held a license for 180 beds, with a census of 126 at the time of the survey.	F 000		
F 576 SS=D	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9)	F 576		5/27/21

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§483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense.

§483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to:
(i) A telephone, including TTY and TDD services;
(ii) The internet, to the extent available to the facility; and
(iii) Stationery, postage, writing implements and the ability to send mail.

§483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:
(i) Privacy of such communications consistent with this section; and
(ii) Access to stationery, postage, and writing implements at the resident's own expense.

§483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research.
(i) If the access is available to the facility
(ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.
(iii) Such use must comply with State and Federal law.

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F 576	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview and facility policy review, the facility failed to deliver mail unopened for two (2) of six (6) residents interviewed in Resident Council. Residents #34 and #122. Findings Include: Resident Council Record review of facility policy titled "Resident's Rights Under Federal Law", undated, revealed "the facility shall protect and promote the rights of each resident, including each of the following rights: the resident has a right to privacy in written communications, including the right to send and receive mail promptly that is unopened." Review of facility policy titled "Resident Rights and Responsibilities", dated 11/28/2017, revealed, "facilities shall adopt the Statement of Resident Rights, in accordance with all Federal and State Regulatory requirements. This facility shall protect and promote the rights of each resident." Revealed "each resident shall have the right to communicate with persons of his/her choice, and may receive mail unopened or in compliance with the policies of the home." A Resident Council meeting was held on 04/08/21 at 11:00 AM. Resident #34 voiced concerns about some of his packages being opened by Social Worker and at times items are removed. Stated he received an electric teapot by mail and that package was not opened by staff, but they did remove this from his room. Stated he also had a	F 576	-The Social Services Department, Activities Department and office staff were in-serviced by the Administrator on Resident's Rights, including delivering the residents mail unopened on April 9, 2021. -The facility has determined that all residents that receive mail have the potential to be affected. -All Department Heads were in-serviced by the Administrator on May 11, 2021 on resident's rights, including the importance of delivering mail unopened to the resident. The Risk Manager will be conducting an audit of five residents weekly for two months beginning May 20, 2021 by interviewing residents to ensure that mail is being delivered unopened. This deficient practice will be discussed at the monthly Resident Council meeting beginning May 18, 2021 and will continue on a monthly basis. -The Risk Manager will bring findings for this audit to the Quality assurance meeting for review and recommendations beginning on May 27, 2021 to ensure that Residents Rights of Privacy are being observed. This will continue until substantial compliance has been met as evidence by no complaints being made of unopened mail.	

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leg brace he ordered, but the staff would not allow him to wear this device since it was not ordered by a doctor. Stated these items are in the social worker's office. Stated he has had other packages that were opened by SW and then he was given the items the SW thought he could have. Stated he ordered a large projector screen so he could watch movies with other residents, but he never received this item. Resident #34 stated the social worker told him the item was received in the facility but since it was too large for his room the SW sent it back. He stated he never saw the item and he has not received his refund from an online distributor (Proper Name) so he is unsure it was sent back. He stated an employee could have taken item. Resident #34 stated he notified the Postmaster General and reported his packages being opened by a staff member. Resident #34 stated he was instructed that they could issue an arrest warrant, but Resident stated he likes the social worker and would not want to do this to him.

An interview on 4/8/2021 at 3:40 PM, with Resident #122 revealed she received a package with a pair of pants and it was opened when she received it.

An interview with the Social Worker on 4/8/2021 at 4:25 PM, revealed he had opened some of Resident #34's packages. The SW stated the resident was receiving items that were not allowed into the resident's room such as lancets for finger sticks and large bottles of Aspirin. He stated the resident also had ordered an electric teapot and a leg brace and these items are being stored in the social workers office. The State Agency surveyor observed these items in the SW office. The SW stated he realizes he should not

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have opened the packages being delivered to the resident and he was trying to ensure safety for the Resident #34, as well as the other residents. He stated he should have had the resident open the packages and ask for permission to look at contents. The SW stated the resident ordered a one hundred inch projector screen that was delivered to the facility, but SW told delivery person to take it back since it was so large. He informed Resident #34 that item had arrived and he had sent it back but he was not aware if Resident #34 had received credit back from where it was ordered from. He stated he was unaware of Resident #75's package being opened. The SW stated he did not open this package and does not know who did.

An interview with the Administrator, on 4/8/2021 at 5:00 PM, revealed she was unaware of residents' packages being opened prior to being delivered to the residents. She stated she was also unaware of Resident #34's projector screen being sent back without the resident's permission. She stated it is each resident's right to receive their mail and packages unopened and confirmed the facility failed to follow the resident rights guidelines to ensure the residents received their mail and packages unopened.

An interview with the Administrator on 4/9/2021 at 9:30 AM, revealed she spoke with Resident #34 concerning his mail and his projector screen. Record review of the invoice for the projector screen revealed it was reordered.

Record review the Face Sheet revealed Resident #34 was admitted to the facility on 10/19/2020 with diagnoses of Type 2 Diabetes Mellitus, Chronic Kidney Disease, Stage 3,

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F 576	Continued From page 6 Cardiomyopathy, Cerebral Infarction. Record review of Resident #34's Minimum Data Set (MDS) dated 10/25/2020, Section C, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating resident with moderate cognitive impairment. Record review of Resident #122's Face Sheet revealed she was admitted to the facility on 1/7/2020 with diagnoses of Type 2 Diabetes Mellitus, Fracture of right femur; Hypertensive Heart Disease. Record review of MDS dated 3/21/2021 , Section C, revealed the Resident had a BIMS score of 15, indicating Resident is cognitively intact. Review of Resident's Rights training revealed the SW was in-serviced on Resident's Rights on 8/17/2020.	F 576		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care for one (1) of four residents reviewed for ADL care. Resident #16. Findings Include:	F 677	-On April 6, 2021 ADL care was immediately provided by the nursing assistants for Resident #16. On April 6, 2021 Resident #16 was assessed by Unit Manager with no skin issues noted. -All dependent residents have the potential to be affected by this deficient practice.	5/27/21

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F 677	Continued From page 7 Review of facility policy titled, "Restorative Program and Activities of Daily Living - Provision of Care, Treatment, and Service: Resident Care", dated 1/9/2015, revealed, "it is the policy of the restorative program to provide the resident with appropriate treatment and services to maintain or improve his or her abilities. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal oral hygiene." On 04/05/2021 at 02:45 PM, an observation of Resident #16 revealed a strong odor of urine in room. Resident was lying in bed with a large sized area of bedsheet and pants noted to be discolored and appeared to be wet with urine, from mid back to below hips. On 4/5/2021 at 2:45 PM, an interview with Resident #16 revealed he was doing fine. Resident appears to be hard of hearing and required fairly loud voice to hear. On 04/05/2021 at 03:10 PM, an observation of Resident #16 revealed a strong odor of urine in room and bedsheet and clothing appeared to be discolored and wet. During an interview on 4/5/2021 at 3:10 PM, Resident #16 stated he was hard of hearing and having difficulty hearing State Agency (SA) trying to speak in a volume that the facility staff in hallway could not overhear. An observation on 04/05/21 at 04:16 PM, revealed Resident #16 lying in bed. Strong odor in room. Resident with discolored bedsheet with large brown ring, pink incontinence pad noted underneath resident that appeared saturated and	F 677	-On April 6, 2021, the Unit Managers and Director of Nursing observed all Residents to ensure that all were groomed and dressed appropriately. On May 13, 2021, an in-service was initiated by the Staff Educator and Unit Managers with all direct care staff addressing ADL care and the reporting of refusals for ADL care. To ensure that the deficient practice does not reoccur, beginning on May 24, 2021 the Unit Managers initiated daily rounds on five Residents for five days per week times three weeks, then five Residents three times per week times two weeks, then five Residents one time per week times one week. Residents who refuse ADL care will be offered care to be rendered by a different staff member. -Beginning on May 27, 2021 the findings will be reported to the facility Quality Assurance Committee for review and recommendations. Quality Assurance committee will review audits to ensure ADL care is being provided for six months until substantial compliance is achieved as otherwise determined by Quality Assurance committee.	

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discolored and resident's right pants leg appeared to be wet from hip to below the knee.

An observation on 04/05/21 at 04:44 PM, revealed Resident #16 lying in bed with strong odor noted. Bedsheet, incontinence pad, and resident's pants appeared to be wet and discolored.

An observation on 4/5/2021 at 05:45 PM, revealed Resident #16 in bed with bedsheet, incontinence pad, and resident's pants discolored and appeared to be wet. Strong urine odor noted in room.

An observation the following morning, on 4/6/2021 at 07:55 AM, revealed resident still lying in bed with strong odor in room noted. Bedsheet, incontinence pad, and resident's pants noted to be stained and damp looking. Pants and shirt were the same clothes resident had on yesterday. A small mark noted on front of pants yesterday was present on pants this morning and made these pants recognizable.

An observation on 4/6/2021 at 8:55 AM, revealed Certified Nurse Aide (CNA) #1, picked up breakfast tray. No request offered by CNA #1 to Resident #16 for care. Resident continued to remain in soiled bed with soiled clothing as previously noted.

An interview on 4/6/2021 at 9:15 AM, with CNA #1 revealed her procedure for her resident rounds. She stated at the beginning and the end of each shift, the oncoming and off-going CNA make rounds. She stated during her initial rounds, she checks to see that the residents are "breathing and dry". She stated if a resident is

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wet or soiled, care is done. She stated baths are started and given until breakfast and then after breakfast, the baths are completed. She stated Resident #16 often refuses to be cleaned up. She stated he was wet this morning, but she did not work this hall yesterday so she was unaware of how long he had been wet. Stated rounds are made at least every 2 hours and the residents should be cleaned as soon as noted to prevent skin irritation.

Observation on 4/6/2021 at 9:30 AM, revealed CNA #1 assisted Resident #16 into the wheelchair and taken down the hall to the shower room. Resident #16 was very cooperative. Resident #16 did not refuse bath and ADL care.

An interview in Resident #16's room, with Director of Nursing (DON) on 4/6/2021 at 9:30 AM, revealed she observed Resident #16's condition in hallway on his way to the shower and observed the resident's soiled bedding. Stated the resident should not be left in that condition. Stated rounds should be made at least every 2 hours and care should be given then. She stated this resident has often refused care. Stated if care is refused, the nurse should be notified. Stated this should be documented. She confirmed the facility failed to provide proper care in a timely manner. Stated when the resident was allowed to remain in wet clothing and bedding for an extended time, the risk of skin breakdown is increased.

An interview on 4/7/2021 at 3:40 PM, with Licensed Practical Nurse (LPN) #2, Quality Assurance Nurse revealed the facility has started Guardian Angel rounds. Stated during these rounds, the department heads periodically go to each resident's room to check on the resident as

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well as the room environment. Stated she had not made rounds on 4/5/2021 or 4/6/2021, so she was unaware of the condition Resident #16 was in. Stated she was unaware resident had been soiled for an extended period of time (at least 19 hours observed during this observation). Stated the resident had refused care in the past and she had seen him soiled and refusing to be changed. Confirmed the resident was not care planned for refusal of care or behaviors. Confirmed the facility failed to provide the resident adequate Activities of Daily Living (ADL) care in an acceptable time frame, and this could lead to skin issues.

Interview on 4/7/2021 at 3:55 PM, with DON. Stated the staff do bedside handoffs at the beginning and end of each shift. Stated the oncoming and off-going CNAs make rounds and the oncoming and off-going nurses make rounds. Stated the staff had mentioned Resident #16's refusal of care on several occasions. Stated some employees are able to get resident to cooperate more than others are. Stated the resident has the right to refuse care. Confirmed the resident was not care planned for refusal of care and the resident had no behaviors documented. Stated there was no documentation of refusal of care during the past several days. DON confirmed the resident did not receive timely ADL care and this could lead to skin breakdown. DON confirmed that if the resident had been refusing care, he should have been care planned for this behavior. The DON confirmed if care was refused, the nurse should have been notified to intervene and documentation concerning event should have been completed. Confirmed that by leaving the resident soiled for an extended period of time (at least 19 hours for this observed

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occurrence), the facility failed to meet Resident #16's ADL needs and increased the likelihood of skin breakdown.

An interview on 4/7/2021 at 4:55 PM, with CNA #2 revealed she had charted that she had given Resident #16 a shower on the evening of 4/5/2021. Stated she was just "trigger happy" when she was charting and Resident #16 did not receive a shower. Stated she worked on 4/5/2021 from 5 PM until 11 PM. Stated she made rounds at 6 PM, 8 PM, and 10 PM. Stated during the 8 PM rounds, she changed the resident's brief and put his dirty, wet pants back on him. Stated she took his pants off for the brief change and put soiled pants back on. Stated she did not report this to the nurse or document event, but stated she should have. Stated the negative outcome of being soiled for an extended time could lead to skin breakdown. Stated at the end of her shift at 10:30 PM, rounds were made with oncoming CNA. Stated she informed the oncoming CNA that resident and bed was soiled and resident did not want his bed to be changed.

An interview on 4/8/2021 at 7:55 AM, with Resident #16 revealed his concerns with ADL care. Stated he has been "left wet" at times and he does not like it. Stated there have been times the staff did not change him quickly.

On 4/29/21, at 10:03 AM, an observation of Resident #16 revealed two (2) CNAs were in his room performing incontinent care. SA introduced self and asked to come in and observe. Resident #16 and staff had no objections. Observation of Resident 's buttocks and peri area revealed no redness or skin breakdown.

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On 4/29/21 at 10:15 AM an interview with the Resident revealed he did not remember being left wet for a long period of time. States his memory is not great but he is doing pretty good for his age, can still walk and chew gum at the same time. The Resident revealed he has no complaints and is getting pretty good care. Revealed they check on him and if he is wet, they will change him.

Record review of a Quarterly Minimum Data Set with an Assessment Reference Date of 4/6/21, Section C, revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognitive skills for daily decision making. Item C1310, Signs and Symptoms of Delirium, revealed disorganized thinking that fluctuates and changes in severity.

Record review of the Body Audit Roster for Resident #16 revealed on 3/30/21 performed with no new skin issues noted, on 4/6/21 performed and with no new skin issues, on 4/13/21 performed and no new skin issues noted, on 4/20/21 performed and no new skin issues noted, and on 4/29/21 performed and with no new skin issues.

Record review of care plan revealed no care plan for refusal of care, bathing, or ADL care.

Record review of care plan revealed a care plan for potential for skin breakdown related to frail skin, age, decreased mobility, episodes of incontinence. Interventions included: encourage/assist to turn and reposition while in bed and use pillows and wedges as needed; incontinence care every 2 hours and as needed (PRN), use moisture barrier after each

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incontinent episode - he is able to toilet self but has frequent episodes of bowel incontinence and occasional episodes of bladder incontinence; notify MD/NP if condition warrants; weekly body audits; pressure relief devices to bed and wheelchair; provide treatments as ordered; keep skin clean and dry; inspect skin daily during bathing and report any redness or areas of concern to treatment or charge nurse; float heels while in bed.

Record review revealed a care plan for requiring assistance with ADLs related to weakness, lack of coordination, unsteadiness on feet, history of shoulder repair. His ADL function varies from day to day. Interventions include: bed mobility with staff assist per needs or request; dress in neat clothing daily with assist per needs or request; hygiene with staff assist per needs or request; incontinent care/assist with toileting every 2 hours and PRN. He is able to toilet self but is occasionally incontinent of bladder and frequently incontinent of bowel; nail care weekly and prn; locomotion on/off unit via wheelchair with assist per daily needs or request; shower 3 x a week with assist per daily needs or request; notify MD/NP if condition warrants; independent with transfers, assist per daily needs or request.

Record review of behavior log revealed the resident had no negative behaviors from January 2021 - 4/7/21. Record review of resident's departmental notes from January 2021 to 4/7/21 revealed no incidents of resident's refusal of incontinent care, ADL care, bathing, or clothing changes were documented.

Record review of the Face Sheet revealed Resident #16 was admitted to facility on 6/3/2019

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F 677	Continued From page 14 with diagnoses of Major Depressive Disorder, Vitamin Deficiency, Mild Cognitive Impairment. Record review of Quarterly Minimum Data Set (MDS) dated 1/7/21, Section C, revealed resident with a Brief Interview of Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. Review of section E - Behavior - revealed for E0800 - Rejection of care: presence and frequency revealed "behavior not exhibited". Section H - Bowel and Bladder - revealed resident was occasionally incontinent of urine and was continent of bowel. Record review of a sign-in sheet signed by CNA #1 revealed she attended the in-service titled, "Incontinent Care Monitoring", dated 11/12/20. Record review of a CNA New Employee Orientation Itinerary, Day 2, revealed CNA #2 was oriented to Activity of Daily Living check-offs on 3/22/2016. CNA#2's name was not identified on the 2/16/2020 or 6/25/2020 CNA training provided by the facility.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		5/27/21

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F 684	Continued From page 15 Based on observation, resident interview, staff interview and facility policy review the facility failed to administer a treatment cream as ordered for a rash for one (1) of six (6) treatments observed. Resident #12. Findings include: Review of facility policy titled "Medication Administration" dated 6/27/2019, revealed, "medications shall be administered only upon the order of physicians, dentists or podiatrists, who are members of the medical staff or have been granted clinical privileges. Up to date medication information shall be available to the individual administering the medication. Available information shall include, but not be limited to: information on drug therapy, side effects, toxicology, dosage, indications for use, route of administration, potential drug to drug interactions, potential allergies or cross sensitivities, proper dose ranges, proper instructions for administration. Medication Administration Record shall be compared with physician orders prior to preparation of any medication. The individual administering the medication shall verify the medication and be aware of the following information concerning each medication before administration: route and frequency of administration, appropriate timing of medication administration." On 04/05/2021 at 11:10 AM, an interview with Resident #12 revealed he had a rash on his lower back, right side of back, and upper right hip and it was uncomfortable for him. Resident stated the staff had put cream on the rash some mornings and nights, but the rash is still bothering him.	F 684	-The missing treatment was administered immediately to resident #12 as ordered on April 7, 2021 per physician order. LPN#7 and LPN #8 were in-serviced by the Director of Nursing initiated on May 12, 2021 and completed on May 14, 2021 on administering treatments as ordered. Resident #12 was assessed by the unit manager on April 7, 2021, with no further issues related to missed treatments. -All residents who receive treatments and medications have the potential to be affected by this deficient practice. A 100% audit of the Medication Administration Record and Treatment Administration Record was completed on May 21,2021 by Medical Records and Unit Managers to ensure all residents received medications and treatments as ordered. -An in-service was initiated with the Treatment Nurses on May 12, 2021 and completed on May 14, 2021 by the Director of Nursing on the importance of administering treatments as ordered ensuring all treatments have been completed and documented before completing their shift. An in-service was initiated on May 6, 2021 by Quality Assurance nurse for all medication nurses on the importance of administering medications as ordered and documented before completing their shift. An audit of all Treatment Administration Records and Medication Administration Records was conducted by the Medical Records nurse and Unit Managers on May 21,2021. The Quality Assurance nurse reviewed the	

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F 684	Continued From page 16 On 04/05/2021 at 4:40 PM, an observation of rash to Resident #12's side under his back. Rash appears moist and red. Unable to see rash to lower back due to resident not feeling like turning. An interview on 4/5/2021 at 4:40 PM, with Resident #12 revealed the rash feels very irritating and uncomfortable and he does not believe he is getting his medication to his rash as ordered. Interview with Licensed Practical Nurse (LPN) #7, Treatment Nurse, on 4/7/2021 at 2:00 PM, revealed the 2:00 PM uncharted medication doses were not given due to oversight. Stated the treatment nurses (herself and LPN #8) were to administer these medications as ordered. Stated for the night doses and other scheduled times when the treatment nurses are not in facility, the nurse on the medication cart would administer these treatments. Confirmed the resident did not receive some of the scheduled doses of cream ordered to improve his skin irritation. Interview with LPN #8, Treatment Nurse, on 4/7/2021 at 2:00 PM revealed the 2:00 PM uncharted medication doses were not given due to oversight. Stated she and LPN #7 administer these treatments on the shifts they work. Stated the treatment nurses were responsible for administering this medication and it was not given as ordered. Stated the resident missed several scheduled doses of this cream medication, ordered to help with resident's skin condition. Confirmed the resident did not received this medication as scheduled and ordered. Interview with LPN #2, Quality Assurance Nurse,	F 684	findings of the audit on May 21,2021 to ensure compliance. -On May 21,2021, the Medical Records nurse began audits on a total of five Treatment Administration Records and five Medication Administration Records weekly for one month, every other week for one month and monthly for one month. Findings from these audits will be taken to the monthly Quality Assurance Committee for review and recommendations beginning on May 27, 2021.	

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on 4/7/2021 at 2:30 PM, revealed the resident was scheduled for doses of Triamcinolone Cream 1% three times a day (TID) as ordered at 6:00 AM, 2:00 PM, and 10:00 PM. Stated the nurses failed to administer medication as ordered, therefore, a medication error occurred. The QA Nurse confirmed the facility failed to administer resident's treatment to improve a skin condition as ordered.

Interview with the Director of Nursing (DON) on 4/7/2021 at 2:30 PM, revealed doses of ordered cream medication were not documented. She stated the treatment nurses are responsible for administering the medication as ordered when they are working. SA informed DON that both treatment nurses confirmed they overlooked the order for this treatment and missed administering this on several occasions, and, also, the resident had stated he only received this medication some mornings and nights. The DON confirmed the facility failed to administer the treatments as ordered to improve Resident #12's skin condition.

Interview with Resident #12, on 4/8/2021 at 2:30 PM revealed his skin irritation has improved. Stated he was getting cream in the morning and at night, but they also put it on a few minutes earlier.

On 4/9/2021 at 5:30 PM, an interview with Resident #12 revealed he is receiving his cream medication and his rash has improved and no longer irritating.

On 4/9/2021 at 5:30 PM, an observation of Resident #12's rash on lower back, upper hips and right side, revealed area dry and not red at this time.

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Record review of orders revealed an order on 4/1/2021 for Triamcinolone cream 1% apply topically to right buttocks and right hip three times a day (TID) for 10 days.

Record review of Medication Administration Record (MAR) revealed Resident #12 was scheduled to receive the medication daily at 6:00 AM, 2:00 PM, and 10:00 PM. Record review of MAR revealed Resident #12 received the ordered cream medication on 4/2/2021, 4/3/2021, 4/4/2021, and 4/5/2021 at 6:00 AM. No documentation of medication being given as ordered on 4/6/2021 and 4/7/2021 at 6:00 AM. Record review of MAR revealed Resident #12 received ordered cream medication on 4/2/2021, 4/4/2021, 4/5/2021, and 4/6/2021 at 10:00 PM. No documentation for ordered medication being given on 4/3/2021 at 10:00 PM. Record review of MAR revealed Resident #12 was scheduled for 2:00 PM medication administration of cream. No documentation for medication being given at this time for 4/2/2021, 4/3/2021, 4/4/2021, 4/5/2021, and 4/6/2021.

Care plan related to potential for skin breakdown related to decreased mobility, incontinence, DM (Diabetes Mellitus) history of yeast, vitamin deficiency. Interventions included: encourage/assist to turn and reposition while in bed, use pillows and wedges as needed; incontinence care every 2 hours and PRN and use moisture barrier after each incontinent episode; notify MD/NP if condition warrants; weekly body audits; pressure relief devices to bed and wheelchair; provide treatments as ordered; keep skin clean and dry; inspect skin daily during bathing and report any redness or areas of

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F 684	Continued From page 19 concern to treatment or charge nurse. Record review of the Face Sheet revealed Resident #12 was admitted to the facility on 12/31/2019 with diagnoses of Acute on Chronic Diastolic (Congestive) Heart Failure, Morbid (Severe) Obesity with Alveolar Hypoventilation, Chronic Diastolic (Congestive Heart Failure), Type 2 Diabetes Mellitus, Alcohol Abuse. Record review of Minimum Data Set (MDS) dated 12/28/2020, Section C, revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating resident is cognitively intact. Record review of MDS dated 12/28/2020, Section G - Functional Status, revealed bed mobility as resident's need for extensive assistance with one person physical assist. Revealed resident with need for total dependence with one person physical assist with bathing. Record review revealed need for extensive assistance with one person physical assist for personal hygiene. Record of Section E - Behavior - revealed for rejection of care - behavior not exhibited. Record review of signed Treatments and Medication Administration Observation check offs noted for LPN #7 and LPN #8 dated 11/18/20.	F 684		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record	F 760	-On April 6, 2021, the Provider was	5/27/21

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F 760	Continued From page 20 review, Pharmacy Consultant, Physician, Nurse Practitioner, and Nurse Consultant interview and facility policy review, the facility failed to ensure residents were free from significant medication errors identified during the preparation and administration of medications for one (1) of nine (9) residents observed during medication administration observation. Resident #9 Findings Include: Record review of the facility policy, "Medication Administration" with a revised date of 6/27/19 revealed, "Up-to- date information shall be available to the individual administering the medication. Available information shall include, but not limited to: Proper instruction for administration...Errors in administration of medication shall be reported immediately to the attending physician and a Notification Form shall be sent to the Nursing Administration ant the Pharmacy by the end of the shift in which the error was committed. The medication administered shall be documented on the medical record. The resident's reaction, if any or if observable, shall be documented in the medical record. Any orders received from the resident's physician and/or any necessary actions taken to protect the resident from the potential effects of the medication error shall be documented in the medical record." Record review of the facility policy titled "Pharmacy Consultant Services", with a revised date 11/28/17, included..."assess the performance of the nursing staff in medication administration through the process of medication pass observation, as requested by the Nursing and Administration and as necessary..."	F 760	notified by the Unit Manager that resident #9 received crushed potassium. The Provider and Director of Nursing assessed resident #9 with no negative findings. Provider changed order to liquid Potassium. On April 6, 2021 LPN #9 was in-serviced by the Staff Educator on preparation and administering of crushed medications. -The Facility has determined that all residents who receive potassium have the potential to be affected by this practice. -An in-service was initiated on May 13, 2021 with all nurses by the staff educator on preparation and administering crushed medications. On May 17, 2021 Unit Managers began observations of crushed medication administration on a total of four residents three times a week for one month, twice a week for one month and then weekly for one month. On May 19, 2021, the facility Pharmacy Consultants reviewed all medications on the crushed medication list. Pharmacy consultants will review residents who receive crushed medications once monthly for six months. Findings of the crushed medication review will be reported to the Director of Nursing and Provider monthly with changes made as ordered by Provider. -Quality Assurance nurse will report findings of this audit monthly to the Quality Assurance Committee beginning May 27, 2021 until such time of consistent substantial compliance is achieved.	

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Record review of the facility policy "Prescribing and Ordering Medications: General Practices" with a revised date of 11/28/2017 did not address crushing of medications.

Record review of "Davis's Drug Guide/Do not Crush" list dated 10/25/16 obtained from B-Hall Upper Cart indicated Klor-Con Tablet, Klor-Con M Tablet (SR) was listed on the "Do Not Crush" list.

In an interview, on 4/8/21, with LPN #11 reports the facility keeps the "Do Not Crush" list in a notebook on the medication carts.

Observation on 4/6/21, at 7:55 AM, with LPN #9 during medication observation, revealed LPN#9 crushed Potassium Chloride (KCL) 20 meq (milliequivalents) to administer to Resident #9.

During an interview with LPN #9 on 4/6/21 at 8:00 AM, confirmed she crushed the potassium chloride tablet and she reported that she had crushed it and given it at least five (5) other times within the last month.

Record review of the Electronic Medication Administration Record (eMAR) for March 2021 revealed LPN#9's initials were noted 13 times on March 8, 9, 12, 14, 17, 18, 22, 23, 26, 27, 28, and 31 on Potassium CL, indicating it had been administered.

In an interview with the Pharmacy Consultant on 4/6/21, at 11:35 AM revealed he recommended to not crush Potassium tablets. He stated it ideally is best to use the liquid form of Potassium. He stated he vaguely remembers a recommendation about this resident and her potassium, but he

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would have to check his record to see.

Record review of the Face Sheet for Resident #9 revealed Resident #9 was admitted to the facility on 9/13/18 with diagnoses which included Hypokalemia and Essential (primary) Hypertension.

Record review of LPN #9's Medication Administration Observation dated 3/10/21, indicated all areas on the medication pass competency was checked as met.

In an interview with the Director on Nurses (DON) on 4/8/21 at 4:55 PM, confirmed LPN #9 had crushed the potassium 4/6/21. She reported the procedure for medication errors would be to immediately notify the physician, monitor the resident, notify the responsible party (RP),notify the DON, carry out any new physician orders, disciplinary actions for the nurse that made the error and re-education. She stated that the physician would give the order for how long to monitor the resident. She further reported that an incident report would be completed. She stated she thinks the root cause of LPN #9's error with crushing the potassium was because she was nervous.

Record review of the nurse's notes dated 3/2/21 through 4/1/21 revealed no documentation of monitoring or any reactions Resident #9 had related to the crushed potassium.

Record review of the Note to the Attending Physician/Prescriber dated 12/30/20 revealed "consider adding a coded diagnosis to the following medications: KCL (potassium)." The Physician/Prescriber response was "agree-add dx

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(diagnosis) CHF (Congestive Heart Failure).

Record review of Physician Orders dated April 2021 revealed an order date of 12/8/20 for Potassium CL ER(Extended Release) 20 MEQ. Give 1 tab (tablet) PO daily (hypokalemia). LPN #9's initials were noted on 4/6/21 at 8 AM, as administered.

Record review of Physician orders dated April 2021 revealed a new order for "potassium CL 10% (20 MEQ/15ML) (milliters). Give 15ML= (20 MEQ) PO DLY."

Record review of Resident #9's Care Plan with a review date of 6/30/21 for Hypokalemia revealed an intervention "Administer medication as ordered."

Record review of untitled notes that were filed under the Physician Progress notes section in the clinical record, dated 1/28/21 through 3/23/21, signed by the attending Physician and Nurse Practitioner, revealed no documentation in the clinical record from the Physician or Nurse Practitioner that crushing medication would not adversely affect the resident.

During an interview on 4/9/21, at 8:45 AM, with the Geriatric Nurse Practitioner (GNP), reported when asked what negative side effects from crushing potassium could be, stated, "It could cause GI (gastrointestinal) upset."

During an interview with the DON on 4/9/21 at 11:00 AM, when asked if crushing a medication that is recommended to not be crushed would be a medication error, she stated, "Yes this would be a medication error."

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F 760	Continued From page 24 During an interview with the Facility Administrator on 4/9/21, at 11:50 AM, stated when asked is crushing an extended-release potassium tablet acceptable, she stated, "You should look to the drug book for guidance about crushing medication." During an interview with the Pharmacy Consultant (PC), on 4/9/21 at 1:00 PM, confirmed he does watch medication pass. He stated, "I have done it in the past." He reported he has not recently completed a medication pass. When asked what the potential side effects of crushing extended-release potassium could be the PC stated, "It's just not going to be as effective. It could cause some GI upset or ulceration. I would recommend not crushing it. I would prefer it be done differently." The PC further stated that the process is that he makes recommendations but lets the DON know before he leaves the facility so she can be working on the recommendations. During an interview on 4/9/21, at 3:45 PM, with Resident #9's primary Physician revealed when asked about the possible side effects of crushing potassium, the Physician stated, "It could cause GI side effects. It doesn't make sense to crush, just use liquid."	F 760		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.	F 773		5/27/21

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F 773	Continued From page 25 (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and facility policy review, the facility failed to obtain a physician's order for blood glucose finger sticks for one (1) of five (5) finger sticks observed. Residents #118 Findings include: Record Review of the Facility policy titled "Diagnostic Services: Lab Tests and X-Ray" with a revised date of 11/28/17 revealed "Procedure: Quality lab tests and radiology services only are performed upon medical order from the resident's physician... When an order is received from a physician requesting blood work to be drawn or an x-ray be taken, the order shall be written on the Physician's Order Sheet.The licensed nurse on duty shall be responsible for inputting the order into the computer." Resident #118 On 04/06/2021 at 8:17AM, an observation of Resident #118 revealed License Practical Nurse (LPN) #4 performed a finger stick blood glucose. On 04/08/2021 at 2:00PM, record review of the April 2021 Physicians Orders revealed there was not a physician order for Finger Stick Blood Glucose.	F 773	-On April 8, 2021, a Physician's Order was obtained by assigned Licensed Practical Nurse for Resident #118 to receive blood glucose checks. -All residents who receive blood glucose finger sticks have the potential to be affected by this practice. -On May 13, 2021 LPN #4 and LPN #5 were in-serviced by RN Staff Educator on obtaining physician's order to complete blood glucose checks as ordered. On May 13, 2021 LPN #6 was in-serviced by RN Staff Educator regarding reviewing residents' records and ensuring physician orders are obtained for residents requiring blood glucose checks. On May 17, 2021 an in-service for Nurses was initiated by the Registered Nurse Educator on obtaining a Physician's Order for all Residents requiring blood glucose finger sticks. On May 12, 2021 a 100% audit was completed by the Medical Records Nurse for all residents who receive insulin to ensure that a blood glucose finger stick order was obtained. -On May 24, 2021 the Medical Records Nurse initiated a review of Residents	

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F 773	Continued From page 26 Record review of Medication Administration Record (MAR) for April 2021 revealed a finger stick blood glucose result is recorded four times a day along with each insulin administration recording for a total of 30 (thirty) times. On 04/08/2021 at 2:30PM, an interview revealed LPN #5 stated the Resident always receives a finger stick blood glucose prior to scheduled insulin administration and it is recorded on the MAR as a special needs that pops up when we chart the insulin. On 04/08/2021 at 3:05PM, revealed LPN #6 Medical Records Nurse stated she had searched the medical records and could not find a written order for the finger sticks as of now.	F 773	Physician Orders to ensure that blood glucose checks were ordered. The audits will be conducted for five residents receiving insulin once a week for three weeks, then five residents receiving insulin one time a week for two weeks, then five residents receiving insulin for one time a week time one week. On May 27, 2021, the Medical Records Nurse will report findings to the facility Quality Assurance Committee for review and recommendations. The audits will continue until substantial compliance is obtained. Substantial compliance will be met when all diabetic residents receiving insulin have blood glucose finger sticks ordered.	
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: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		5/27/21

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F 880	Continued From page 27 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 identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 28 §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 observation, staff interview, physicians' interview, review of the manufacturer's instructions for glucose meter (glucometer), insert for germicidal wipes used at the facility, resident record review, and facility policy review, the facility (a.) failed to ensure nursing staff cleaned and disinfected a multi-use glucometer before and after fingerstick blood glucose testing for three (3) of five (5) sampled residents observed for blood glucose fingersticks, Residents #15, #27, and #122 and (b.) failed to perform proper hand hygiene and glove use for (4) of 5 sampled residents, Residents #15, #27, #122, and #230 and (c.) failed to use a barrier and perform hand hygiene for one (1) of 5 sampled residents observed during blood glucose monitoring for Residents #230. This practice had the potential to affect 32 of 32 residents who received blood glucose monitoring, out of a total of 43 residents with Diabetes. The facility's failure of not following standard precautions for infection control by not disinfecting the glucometer between residents, placed these and other residents who received blood glucose finger sticks (32 total residents out of 42 diabetic residents) in a situation which caused a likelihood of serious injury, harm, impairment, or death, related to the spread of	F 880	-All Residents receiving glucometer checks were immediately assessed by the unit managers with no signs or symptoms of infection or adverse reactions. All non-EPA approved wipes were removed immediately from all medication carts and supply rooms on April 7, 2021 and were replaced with EPA approved wipes per manufacturer□s instructions. All glucometers were cleaned with EPA approved wipes. The facility had a total of 12 multi patient glucometers in use. An emergency Quality Assurance meeting was conducted on April 7, 2021 at 10:00am with the following: Medical Director, Nurse Practitioner, Director of Nursing, Infection Preventionist, Quality Assurance Nurse, Administrator and Assistant Director of Nursing on the deficient practice. LPN #9, LPN #10 and LPN #1 were in-serviced by an Infection Prevention Nurse from another facility on April 7, 2021 on cleaning and disinfecting the glucometer before and after usage. This in-service also included proper hand hygiene. All nurses were in-serviced starting on April 7, 2021 on cleaning and disinfecting the glucometer before and after usage with return demonstration by	

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F 880	Continued From page 29 blood-borne pathogens due to cross-contamination with the multi-resident use of the glucometer. The situation was determined to be an Immediate Jeopardy (IJ), which began on 4/6/21 at 7:40 AM, when Licensed Practical Nurse #9 failed to clean and disinfect a multi-use blood glucometer per manufacturer's guidelines before and after use. The facility failed to follow standard precautions of infection control while performing blood glucose finger sticks without cleaning/disinfecting the Glucometer before use between three (3) residents. IJ existed at: 483.80 Infection Prevention & Control CFR (s): 483.80(a)(1)(2)(4)(e)(f) - F 880 - Scope and Severity "K" The State Agency (SA) notified the Administrator on 4/7/21, at 9:20 AM, of the IJ and provided the Administrator with the IJ Template. An acceptable Removal Plan was received on 4/8/21, in which the facility alleged all actions were completed on 4/8/21, and the IJ was removed as of 4/8/21. The SA validated the Removal Plan and determined the IJ was removed on 4/9/21, prior to exit. The scope and severity for CFR(s) 483.80(a)(1)(2)(4)(e)(f),was lowered from a "K" to a scope and severity of a "E", while the facility develops and implements a plan of correction and monitors the effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements.	F 880	an Infection Prevention Registered Nurse. This Infection Prevention Registered Nurse is not employed by this facility. This in-service also included proper hand hygiene. -The facility determined that all residents that are receiving glucometer checks have the potential to be affected by this practice. -To prevent this deficient practice from reoccurring on April 7, 2021, all Licensed Nurses were in-serviced on cleaning and disinfecting the glucometer before and after usage by an Infection Prevention Registered Nurse who was not employed with this facility, this in-service included proper hand hygiene. The supply clerk was in-serviced by Risk Manager on April 12, 2021 regarding ordering and stocking the correct EPA approved wipes for cleaning and disinfecting the glucometers. LPN #9, LPN #10 and LPN #1 were also in-serviced with return demonstration by Infection Preventionist on May 12, 2021 on cleaning and disinfecting the glucometer before and after usage. This in-service also included proper hand hygiene. An in-service was started on May 17, 2021 with all nursing staff to review proper hand hygiene and cleaning and disinfecting glucometers before and after usage by Quality Assurance Nurse. On-going in-services with return demonstration continue to be conducted by unit managers and Quality Assurance nurses. Quality Assurance Nurse will conduct weekly audits with three nurses	

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F 880	Continued From page 30 Findings include: Record review of the facility policy titled, "Surveillance Plan" revised date 11/28/2017, revealed ... "Process Surveillance" reviews practices directly related to resident care, to identify compliance with established policies and procedures based on recognized guidelines. Process Surveillance determines for example if the facility has and implements procedures in place to: ...b. Use appropriate hand hygiene prior to and after all procedures ...h. ensure proper that reusable equipment is appropriately cleaned, disinfected, or reprocessed. Record review of the facility policy titled, "Standard Precautions", effective date 9/19/14, revealed "It is the policy of (Proper Name of Management Company) facilities to provide patient care services that reflects the "Standard Precautions" infection control practices when interacting with residents. Standard Precautions components include, but are not limited to, the following: Hand Hygiene... Record review of the facility policy titled "Infection Prevention Program", revised date 11/28/17, revealed "Education of Staff, Residents and Visitors: Education addressing the principles and practices for the preventing transmission of infectious agents shall be provided to all facility staff, as well as anyone who may have direct or indirect contact with the residents or medical equipment..." A review of the Center for Disease Control and Prevention guidelines last updated 6/8/17, regarding shared blood glucose meters, revealed if blood glucose meters were shared, the device	F 880	on hand hygiene and cleaning and disinfecting the glucometer for six months starting on May 17, 2021. -Quality Assurance nurse will report findings of this audit to be reviewed by the Quality Assurance Committee monthly beginning May 27, 2021 until such time of consistent substantial compliance is achieved. Quality Assurance committee will review audits to ensure that residents receive proper blood glucose checks including cleaning and disinfecting the glucometer appropriately and staff are performing proper hand hygiene for six months until substantial compliance is achieved as otherwise determined by Quality Assurance committee.	

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should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents.

Record review of a policy presented by the facility related to disinfection of equipment titled "Infection Control", with a revised date of 11/28/17, revealed, "It is the policy of (Proper Name of Management Company) facilities to operate in compliance with Environmental Protection Agency (E.P.A.) guidelines for the management of healthcare associated infections. (H.A.I.)... Procedure: E.P.A. approved products shall be used for disinfecting in the event of H.A.I. Appropriate supplies shall be available in each resident area." The policy did not specifically address the cleaning of glucometers.

In an interview on 4/9/21 at 10:30 AM with the Risk Manager stated when asked about a policy on disinfection of equipment policy, "This is the disinfection policy." RN #4 presented the policy "Infection Control" with a revised date of 11/28/17.

Resident #122

An observation on 4/6/21 at 7:40 AM, revealed Licensed Practical Nurse (LPN) #9 took the glucometer out of the top drawer of the medication cart and did not disinfect the glucometer. While at the medication cart, LPN #9 did not wash her hands or use hand sanitizer. LPN #9 entered Resident #122's room. LPN #9 performed the blood glucose fingerstick using the EVENCARE G3 meter, placed the meter back on the tray, then removed her gloves while in the resident room and performed hand hygiene. LPN #9 returned to the medication cart, put on gloves, and wrapped the meter in a MAGICARE

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Premium Alcohol wipe. LPN #9 removed her gloves and did not perform hand hygiene.

Record review of Resident #122's Face Sheet included diagnoses of Type 2 Diabetes Mellitus with hyperglycemia and Type 2 Diabetes Mellitus with diabetic neuropathy, unsp (unspecified). Resident #122's Minimum Data Sheet (MDS) with an Assessment Reference Date (ARD) dated 3/21/21 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #122 was cognitively intact. Resident #122's Electronic Medical Record (eMAR) for April 2021 revealed a blood glucose documented on 4/6/21 at 7:30 AM and signed by LPN #9.

Resident #27

An observation of a blood glucose fingerstick using the EVENCARE G3 meter on 4/6/21 at 10:05 AM, with Resident #27, revealed LPN #9 took the glucometer out of the top drawer of the medication. LPN #9 did not disinfect the glucometer, she did not wash her hands or use hand sanitizer prior to putting gloves on. LPN #9 entered Resident #27's room. LPN #9 performed the blood glucose fingerstick using the EVENCARE G3 meter and placed the meter on the tray. LPN #9 removed her gloves. She did not perform hand hygiene. LPN #9 returned to the medication cart, put on gloves, and wrapped the meter in a MAGICARE Premium Alcohol Wipe. LPN #9 removed her gloves and did not perform hand hygiene.

Record review of Resident #27's Face Sheet revealed Resident #27 was admitted to the facility on 2/7/12. Resident #27 diagnoses included Type 2 Diabetes Mellitus with hyperglycemia. Resident

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#27's MDS with an ARD dated 1/13/21 for revealed a BIMS score of 15 which indicated Resident #27 was cognitively intact. Record review of Resident #27's Administration Record (EMAR) for dated 4/6/21 revealed a documented blood sugar at 10:09 AM.

Interview on 4/6/21 at 10:10 AM, with LPN #9 revealed she had not performed any other blood glucose fingersticks since the earlier one on Resident #122. LPN #9 stated that she used the alcohol wipes to disinfect the glucometer because this is how she was oriented when she was hired one month ago. SA asked LPN #9 if she had any other wipes in the cart, and she produced Micro-Kill Germicidal Alcohol wipes that were in the medication cart drawer. When asked what she used the Micro-Kill Germicidal Alcohol wipes for, she stated that she cleans the medication cart off with them when she finishes her medications for the shift. She was asked why she did not use the Micro-Kill Germicidal Alcohol wipes on the glucometer. She stated because they told me to use alcohol wipes and that is why they stay in the top drawer. She was asked who told her to use the alcohol wipes and she stated the supervisor. She stated I do not know her name. She is in one of the front offices, but she is not the Unit Supervisor.

Resident #15

An observation of a blood glucose fingerstick using the EVENCARE G3 meter, on 4/6/21 at 8:05 PM, with Resident #15, revealed LPN #10 gathered her supplies to include the glucometer. She did not disinfect the glucometer and did not wash her hands prior to putting on gloves. She entered Resident #15's room and placed the

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glucometer on the overbed table with no barrier. LPN #10 performed the blood glucose fingerstick using the EVENCARE G3 meter, removed her left glove, and held the meter in her gloved right hand. LPN #10 returned to the medication cart and placed a clean glove on her left hand. LPN #10 got a Micro-Kill Germicidal Alcohol wipe out of the container, using her left hand, and wrapped the meter up. She stated she will leave it wrapped up for two (2) to five (5) minutes. She removed her gloves and did not wash her hands.

Review of the Micro-Kill containter label, "Directions For Use: Disinfecting: To disinfect hard, non porous surfaces, use one or more wipes, as necessary, to thoroughly wet the surface to be treated. Treated surface should remain visibly wet for one minute to achieve complete disinfection of all pathogens listed on this label." The label included effective disinfection of 12 Bactericidal and 11 Virucidal pathogens which included Hepatitis B, Hepatitis C and Human Immunodeficiency Virus (HIV).

Record review of Resident #15's Face Sheet revealed Resident #15 was admitted to the facility on 6/6/14. Resident #15's diagnoses included Type 2 Diabetes Mellitus with hyperglycemia. Resident #15's e-MAR for April 2021 revealed a blood glucose had been obtained for 4/6/21 at 8:00 PM and was initialed by LPN #9.

During an interview with LPN#10 on 4/6/21 at 8:10 PM, the SA asked LPN #10 had she used the glucometer prior to this fingerstick and LPN #10 stated, no and that this was the first fingerstick she had done on this shift. The SA asked LPN #10 was the glucometer clean when she removed it from the drawer. LPN #10 stated

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that she should have cleaned it before using it. She stated she should have washed her hands before and after performing the fingerstick. LPN #10 stated that she was hired in August and completed the new hire videos and computer trainings. LPN #10 stated that she was put with random nurses for orientation to the medication cart and procedures. LPN #10 stated that she was taught to wash her hands, put gloves on, disinfect the glucometer using the Micro-Kill Germicidal Alcohol wipes and keep it wrapped up for two (2) to five (5) minutes, perform the accu-check, disinfect the glucometer, and wash her hands.

Resident #230

On 04/06/21 at 08:05 PM, an observation of a bedside fingerstick glucose for Resident # 230 performed by Licensed Practical Nurse (LPN) #1, revealed LPN #1 carried a disinfected glucometer and supplies into the room on a barrier and placed it on the bedside table. LPN #1 wore gloves into the room. She removed the glucometer from the barrier and placed in it on a chair while she performed the fingerstick. LPN #1 did not remove her gloves and perform hand hygiene when she completed the fingerstick blood glucose. With the same gloves on, LPN #1 picked up a pair of pajamas from the bed and held them in her right hand while she administered oral medications to Resident #230. She exited the room, removed her gloves at the medication cart and appropriately disinfected the glucometer with disinfectant wipes and then used hand sanitizer.

An interview, on 4/6/21 at 8:15 PM, with LPN #1, revealed that she realized she put the glucometer

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on the chair and should not have done that. She stated that she contaminated the monitor when she placed it on the chair. She stated she should have removed her gloves when she finished with the fingerstick, because her gloves were contaminated, and she could have spread germs by touching the other things in the room.

On 04/08/21 at 09:25 AM, an interview with LPN #2, Infection Preventionist, revealed that staff should remove gloves between procedures and perform hand hygiene. LPN #2 stated that LPN #1 should have removed her gloves when she finished the blood glucose fingerstick and performed hand hygiene before touching anything else because of possible contamination with blood. LPN #2 confirmed the glucometer should always be placed on the barrier. The purpose of the barrier is to prevent contamination of the glucometer.

Record review revealed LPN #1 performed a glucometer competency checklist on 11/19/20 with instruction to wash hands following the proper disposal of the used test strip.

An interview on 4/8/21 at 11:10 AM with RN #2, Unit Supervisor. RN #2 stated she is responsible for any of the glucometer audits for the nurses and she stated that she does random audits but, she has not had a new nurse on her unit but if she had, that she would do the audit. The SA asked RN #2 if someone failed to wash their hands or disinfectant the glucometer, what could be a concern and RN #2 stated you could take something from one resident to the next resident. RN #2 stated residents do not have their own personal glucometers, unless on isolation.

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During an interview on 4/9/21 at 10:45 AM with the Corporate Nurse Consultant (CNC) reports her role is to oversee the facility is following State and Federal Regulations. She states that "in the past I have discussed ways to do glucometer checks and med pass. I also help with protocols and policies. When asked about any negative outcomes of not washing hands appropriately or not cleaning and disinfecting the glucometer the CNC stated, "We expect the Director of Nurses (DON) and Infection Preventionist (IP) to carry out task. It's an infection control issue." When asked about nurses following policies that had been implemented by the facility the CNC confirmed nurses should follow the established policies.

During an interview with on 4/9/21 at 11:00 AM, with the Director of Nurses, (DON) stated there were no infections in the facility. The DON reports that when a nurse is hired, they are trained during orientation on medication pass and glucometer checks, then that is validated by a preceptor. The competencies should be completed within the same month. She stated when asked about the outcome of not properly cleaning the glucometer, "There would be a risk for transmission of infection from resident to resident. "She further reports that hand hygiene should be used before entering the resident's room and when completing a task and gloves are supposed to be worn with any risk of coming into contact with bodily fluids. When asked about in-services on infection control the DON reports that in-services are done "Quite frequently. They do audits annually and also do weekly and monthly audits. We completed a skills fair in November." The DON reports that "nurses should be following CDC (Centers of Disease Control) guidelines

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when cleaning glucometers.

During an interview with the Facility Administrator on 4/9/21 at 11:50 AM, stated when asked should nurses clean the glucometer according to established guidelines, she stated, "Yes they should be following CDC guidelines. It was a deficient practice. I don't argue it's a deficient practice." She further stated, "I'm know I'm responsible to see there are people to follow the guidelines. I know it all sets with me."

During an interview with Resident # 122's primary Physician on 4/9/21 at 3:45 PM, when asked if he was aware of an issue with the facility related to glucometer cleaning. The Physician reports he was aware. When asked about negative outcomes he reports "it's an infection control issue. It's unfortunate."

During an interview with the Medical Director, on 4/9/21 at 4:05 PM, when asked what a negative outcome would be if nurses did not properly clean the glucometer, the Medical Director stated, "If they didn't clean it at all, blood could potentially come in contact with the nurses' gloves and get on the glucometer. It could be a blood borne pathogen hazard, it's infection control."

A review of the Manufacturer's User Guide for the "EVENCARE G3" glucose monitor (used by the facility), revealed under section titled "Cleaning and Disinfecting Procedures for the Meter" the meter should be cleaned and disinfected between each patient. The following products have been approved for cleaning and disinfecting the EVENCARE G3 Meter:
Dispatch Hospital Cleaner Disinfectant Towels with Bleach (EPA registration #56392-8)

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Medline Micro-Kill Disinfecting, Deodorizing, Cleaning Wipes with Alcohol (EPA registration #59894-10),Clorox Healthcare Bleach Germicidal and Disinfectant Wipes (EPA registration 67619-12), Medline Micro-Kill Bleach Germicidal Bleach Wipes (EPA registration #37549-1).

A review of the manufacturer's package of MAGICARE PREMIUM DISINFECTING WIPES (used by the facility in the deficient practice) revealed the ingredients are 75% alcohol and water.

Review of an untitled document on facility letterhead provided by the facility dated 4/8/21 and signed by the Administrator revealed, "Prior to April 7, 2021 (proper name of facility) did not have a policy to clean glucometers." Record review of a typed statement on facility letterhead dated April 9,2021, revealed "This facility does not have a specific policy on hand washing and gloves. We follow CDC guidelines." The document was signed by the Facility Administrator.

Record review of a document typed by the facility dated 4/9/21 "Diabetic Residents at OHR"revealed there were 42 resident names listed on the diabetic list. Another list provided by the facility "Diabetic Residents at OHR with Blood Sugar Checks" revealed 32 residents receive blood sugar checks.

Record review of a typed statement from LPN #2, Infection Preventionist, revealed that during the week of the annual survey, there was zero residents in the facility that had the diagnoses of Hepatitis B, Hepatitis C, Human Immunodeficiency Virus, or Clostridioides difficile.

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Record review of an Inservice Attendance Record dated 3/12/21 with an attached agenda included handwashing/infection. LPN#9 or LPN#10's names were not listed as having attended the in-service.

Record review of an Inservice Attendance Record dated 3/31/21 with a brief description of the in-service revealed "Glucometer check off regarding cleaning-disinfecting & proper procedure checking blood sugars." LPN #1, LPN #9 and LPN #10's names were listed as an attendees.

Record review of LPN #10's "Licensed Nurse Competency" dated 8/24/20 revealed LPN #10 had a check mark under Basic Nursing Skills-Capillary blood glucose with a completion date listed as 8/26/20 and under Medication Management- Glucometer checks with a completion date listed as 8/27/20..

Record review of a "Glucometer Competency Checklist" dated 9/13/20 revealed LPN #10 had "Yes" marked under each skill observed and documentation indicated, "Nurse Passed Competency Check -Yes."

Record review of LPN#9 "Licensed Nurse Competency" dated 3/1/21 revealed LPN #9 had a check mark under Basic Nursing Skills-Capillary blood glucose and under Medication Management-Glucometer checks with a completion date listed as 3/1/21.

Record review of the "General Orientation Checklist" dated 3/1/21 for LPN # 9 revealed "General Purpose: This check list outlines the

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information, which new employees will want to become familiar with during his/her introduction period." The orientation checklist included, "Infection Control."

Record review of a "Glucometer Competency Checklist" dated 3/10/21 and 4/8/21 revealed LPN #9 had "Yes" marked under each skill observed and documentation indicated, "Nurse-Passed Competency Check -Yes."

The facility provided an acceptable Removal Plan for the IJ on 4/8/21. Review of the facilitys Removal Plan revealed the facility took the following actions to remove the IJ:

Removal Plan

The facility took the following actions to address the citation and prevent any additional residents from suffering any adverse outcome.

On 04/06/21, a licensed nurse cleaned the glucometer with a 75% alcohol Magi care disinfectant wipe. The facility failed to properly clean a glucometer and disinfect the multi-patient resident use glucometer (Evencare G3 meter) per Environment Protection Agency (EPA) registered disinfectant observed for Resident #15, Resident #27, and Resident #122. This nurse was previously in-serviced on March 31, 2021. She completed her competency with accuracy by using the appropriate EPA approved disinfectant wipe. Each unit manager conducted a physical assessment on all residents that have an order for glucometer checks.

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1. Thirty-six (36) residents have an order for a glucometer check. They were assessed by the unit managers with no signs or symptoms of infection or adverse reactions.

2. All Magi wipes were removed immediately from all medication carts and supply rooms on April 7,2021 and were replaced with EPA approved wipes per manufacturer's instructions. All Glucometers were cleaned with EPA approved wipes. The facility has a total of 12 multi patient glucometers in use.

3. An Emergency QA meeting was conducted on 04/07/21 at 10:00 AM with the following: Medical Director, Nurse Practitioner, DON, Infection Preventionist, QA nurse, Administrator and ADON on the Immediate Jeopardy and removal plan for proper cleaning of glucometers. Immediately, a directive in-service began and was conducted by RN #1 and RN #2 for all Licensed Nurses on proper disinfection on glucometer check with return demonstration. Neither of these individuals are employees of this facility. The following topics were discussed in the QA meeting.

a. All diabetic residents at risk to suffering adverse outcomes

b. Removal of Magi care wipes from all medication carts

c. Directive in-services for all licensed nurses

d. Policy revision on Glucometer Disinfection.

4. A Directive in-service began on 04/07/21 being conducted with all Licensed nurses by RN #1 and

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RN #2. The in-service consists of appropriate technique, including a return demonstration on properly cleaning and disinfection glucometers before and after each use. All nurses will be educated prior to their next shift and no staff will be allowed to work until properly in-serviced. A total of 41 out of 57 nurses have been in-serviced at this time.

Facility asserts that it is in compliance on April 8, 2021 at 10:00 AM.

On 4/9/21, the SA validated the facility's Removal Plan through observation, staff interviews, record reviews, and review of in-service sign-in sheets. The SA verified the facility had implemented the following to remove the IJ:

1. Interview with the DON and Nurse Practitioner revealed that the thirty-six (36) residents with an order for a glucometer check were assessed by the unit managers with no signs or symptoms of infection or adverse reactions.

2. Observation of all medication carts verified that all Magi wipes were removed immediately from all medication carts and supply rooms on April 7,2021 and were replaced with EPA approved wipes per manufacturer's instructions. Interview with the DON revealed all Glucometers were cleaned with EPA approved wipes. The facility has a total of 12 multi patient glucometers in use.

3. Interview with the DON, Nurse Practitioner and Administrator and record review of the sign-in sheets revealed an Emergency QA meeting was conducted on 04/07/21 at 10:00 AM with the following: Medical Director, Nurse Practitioner, DON, Infection Preventionist, QA nurse,

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Administrator and ADON on the Immediate Jeopardy and removal plan for proper cleaning of glucometers. The following was discussed: All diabetic residents at risk to suffering adverse outcomes, Removal of Magi care wipes from all medication carts, Directive in-services for all licensed nurses, Policy revision on Glucometer Disinfection. Immediately, a directive in-service began and was conducted by RN #1 and RN #2 for all Licensed Nurses on proper disinfection on glucometer check with return demonstration.

4. Interview with the DON and eight nurses and record review of the sign-in sheets revealed a Directive in-service began on 04/07/21 being conducted with all Licensed nurses by RN #1 and RN #2. The in-service consists of appropriate technique, including a return demonstration on properly cleaning and disinfection glucometers before and after each use. All nurses will be educated prior to their next shift and no staff will be allowed to work until properly in-serviced. A total of 41 out of 57 nurses have been in-serviced at this time.

The SA validated that all corrective actions to remove the IJ had been completed as of 4/8/21, and the IJ was removed on 4/9/21, prior to exit.