STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255102	A. BUILDING _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF RIPLEY	101 CUNNINGHAM DR RIPLEY, MS 38663

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey along with a complaint investigation for MS00018141 at the facility from 11/07/21 through 11/10/21. During the survey, the SA found that the facility was not in compliance with Medicare and Medicaid regulations and cited F689 related to accident and hazards, F695 related to respiratory/oxygen therapy, F761 related to storage of medications and F880 related to infection control. The SA was not able to substantiate the facility reported incident/complaint for MS00018141. The facility held a license for 140 beds and had a census of 106.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility policy review the facility failed to provide residents with a safe environment, as evidenced by, a can of chemical disinfectant spray found unsecured on an open linen cart for one (1) of four (4) days of survey. Findings include: Review of the facility policy titled, "Internal	F 689	F689 -The center addressed the corrective action for those residents found to have been affected by the deficient practice by the Registered Nurse Supervisor removing the can of disinfectant spray from the cart on 11/7/21. On 11/7/21, the nursing staff searched the entire center for any other potentially hazardous chemicals left unsecured. None were	12/20/21

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

Electronically Signed | 11/29/2021

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

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F 689	Continued From page 1 Hazardous Materials Incident", no date, revealed, "Overview: Several hazardous chemical materials are stored and used within the center every day within several areas and departments. Examples include, but are not limited to: ...Nursing: Alcohols, disinfectants, and hazardous drugs... Preventing Accidental Exposure, Spills, and Releases...All chemicals stored within resident care areas will be secured in locked cabinets when not in use..." An observation on 11/7/2021 at 3:00 PM, revealed a can of chemical disinfectant spray on the clean linen cart on D hall. An interview on 11/7/21 at 3:02 PM, with Registered Nurse (RN) #3 revealed the disinfectant spray should not be on the clean linen cart. RN #3 removed the can. She stated that the staff knows that the spray is not supposed to be on the cart. An interview on 11/7/21 at 3:15 PM, with Certified Nursing Assistant (CNA) #3 confirmed the chemical spray should not be on the linen cart. She stated that a resident could possibly get it and hurt themselves or make them sick. CNA #3 stated that the can was there (on the open linen cart) when she came to the floor and she should have removed it then. An interview on 11/10/21 at 10:20 AM, with the Director of Nursing (DON), revealed that she did not know how the chemical disinfectant spray got on the linen cart unless, it was due to their recent COVID positive resident, and somebody put it on there to spray themselves. She confirmed that the disinfectant spray should not have been on the linen cart. The DON stated that the chemical	F 689	found. -The center identified that all residents have the potential to be affected by the same deficient practice. -To avoid recurrence of the deficient practice, the facility Administrator implemented systemic changes that included assuring locked storage areas were made available on each unit for storage of hazardous chemicals on 11/7/21. On 11/9/21, the Director of Nursing, Assistant Director of Nursing, and the Director of Clinical Education initiated an inservice to staff regarding proper storage of hazardous chemical materials. All chemicals stored within resident care areas will be secured in locked cabinets when not in use.¿ -The center plans to monitor the effect of the systemic changes to make sure the solutions are sustained by the Administrator, Director of Nursing, Assistant Director of Nursing, and Registered Nurse Supervisors rounding in center three times weekly for three weeks beginning on 11/29/21, two times weekly for two weeks, and weekly times two weeks to ensure proper storage of hazardous chemicals. Any negative findings will be corrected immediately and addressed with one on one inservicing and/or the center's progressive discipline policy. Findings will be addressed in the monthly Quality Assurance Performance Improvement meeting beginning in the December 2021 meeting scheduled on the 20th by the interdisciplinary team for review monthly for two months then as deemed necessary by the Quality	

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F 689	Continued From page 2 could be harmful if a resident got it.	F 689	Assurance committee .¿ Date of Completion: 12/20/21	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to store nebulizer tubing in a manner to prevent the possible spread of infection and failed to date oxygen tubing for three (3) of eight (8) residents with oxygen and nebulizer equipment. Resident #45, Resident #46 and Resident #70. Findings include: Resident #46 An observation on 11/07/2021 at 3:25 PM, of Resident #46 revealed oxygen (O2) at two point five (2.5) Liters per minute/ by nasal cannula (LPM/BNC) with the aqua pack (water bottle) dated 11/6/21. The O2 Tubing was not dated. A nebulizer machine was on the bedside table with tubing and mask attached. The mask was laying on top of the nebulizer and it was not in a zip lock bag. There was no plastic bag observed near the	F 695	F695 -The center addressed the corrective action for those residents found to have been affected by the deficient practice by the Director of Nursing and Assistant Director of Nursing immediately assessing residents #45, #46, and #70 with no adverse findings noted on 11/7/21. On 11/7/21, the Director of Nursing identified all residents with an order for oxygen and nebulizer therapy. Nursing Management ensured all oxygen tubing, humidifier bottles, nebulizer masks/tubing were changed out with dates on all and plastic bags provided for storage on 11/7/21.¿ -The center identified that any residents with oxygen and/or nebulizer therapy has the potential to be affected.¿100% audit of all residents with oxygen and nebulizer therapy was completed by the Director of Nursing on 11/7/21 with any negative	12/20/21

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F 695	Continued From page 3 nebulizer or O2 concentrator to prevent the spread of infection. Record review of the Admission Record for Resident #46 revealed she was admitted to the facility on 4/7/2021 with diagnoses of Chronic Obstructive Pulmonary Disease, Morbid Obesity, Heart Failure, unspecified and Unspecified Atrial Fibrillation. Record review of Resident #46's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/28/21, revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderately impaired cognition. Record review of Resident #46's Clinical Physician Orders, last review date 11/1/21, revealed Oxygen concentrator every shift for (shortness of breath) SOB, acute respiratory. distress, SaO2 (oxygen saturation) < 90% May infuse 2-4 LPM BNC, revision date 09/27/21. Ipratropium-Albuterol Solution 0.5-2.5 three (3) MG/3ML, 3 ml inhale orally via nebulizer every four (4) hours as needed for SOB related to Chronic Obstructive Pulmonary Disease unsupervised self-administration dated 05/11/21. Change oxygen tubing and humidifier bottle weekly. Clean any external filters with soap/water, every night shift every Fri. Change nebulizer mask and tubing every three (3) days, every night shift every 3 day(s) dated 4/7/2021. Resident #70 An observation on 11/07/2021 at 4:30 PM, of Resident #70's room revealed no Aqua Pack (water bottle) attached to the O2 concentrator and the O2 tubing was not dated.	F 695	findings corrected by Nursing Management.¿ -To avoid recurrence of the deficient practice, the facility implemented systemic changes that included inservicing by the Director of Nursing and Assistant Director of Nursing regarding oxygen and nebulizer therapy on 11/7/21. Education included that nebulizer masks are to be changed every three days on nightshift, nebulizer masks should be dated when changed and stored in a plastic bag; oxygen tubing and humidifier bottles are changed once weekly (every Friday night) per nightshift, oxygen tubing and humidifier bottles are both to be dated and a plastic bag should be taped to the concentrators for tubing storage when not in use. The Director of Nursing, Assistant Director of Nursing, or Unit Mangers will complete weekly audits beginning 11/29/21 of residents with oxygen therapy ensuring both the humidifier bottles and oxygen tubing are dated, also ensuring all have a plastic bag for storage. -The center plans to monitor the performance of the systemic changes to make sure the solutions are sustained by the Director of Nursing, Assistant Director of Nursing, or Registered Nurse Supervisor completing oxygen and nebulizer infection control rounds beginning on 11/29/21 three times weekly for two weeks, twice weekly for two weeks, then continue once weekly audits for four weeks. Any negative findings will be corrected immediately and addressed with one on one inservicing and/or the center's progressive disciplinary policy.	

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F 695	Continued From page 4 Record review of Resident #70's Order Summary Report revealed an order dated 08/13/21 for oxygen concentrator every day and evening shift , may infuse at 5 LPM BNC during wake hours. Resident #45 On 11/07/21 at 05:17 PM, an observation revealed Resident #45 had no date on the O2 tubing. A nebulizer mask with tubing attached but not to the machine was laying on the bedside table near the nebulizer machine. Record review of Resident #45's "Order Summary Report" revealed an order dated 10/10/2020 for Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML one (1) vial inhale orally every six (6) hours as needed for SOB/decreased SAO2 related to Chronic Obstructive Pulmonary Disease, unsupervised self-administration and an order dated 9/27/21 for Oxygen concentrator as needed for SOB/respiratory distress may infuse 2-4 LPM BNC. On 11/09/2021 at 2:10 PM, an interview with the Director of Nurses (DON) revealed it was the standard in the facility to change O2 tubing and water bottles weekly. Usually the order is to be changed on Friday night and they date the water bottle but not the oxygen tubing. The nebulizer tubing and mask are changed every three days and they date the mask. We store mask and cannulas in plastic bags when not in use. The DON confirmed that the nebulizer mask and the oxygen cannulas should have been stored in plastic bags. On 11/10/2021 at 9:00 AM, an interview with the	F 695	Findings will be discussed in the Quality Assurance Performance Improvement meeting beginning in the December 2021 meeting scheduled on December 20th by the interdisciplinary team monthly for two months then as deemed necessary by the Quality Assurance committee.¿ Date of Completion: 12/20/21	

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F 695	Continued From page 5 DON revealed when asked what could happen if the O2 tubing itself was not changed but the water bottle got changed, she replied that it could cause bacteria growth or make the resident sick. When asked for a policy for changing and dating O2 tubing the DON denied that the facility had a policy that spoke to dating of the oxygen tubing and stated we go by the physician orders and chart it on the medication administration record.	F 695		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		12/20/21

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F 761	Continued From page 6 by: Based on observation, staff interview and facility policy review the facility failed to secure the medication cart on hallway C and hallway D while away from the medication cart during medication administration for three (3) of nine (9) medication administration opportunities on halls B, C, and D. Findings include: Review of policy titled, " 5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" with an effective date 12/01/07 revealed "APPLICABILITY This Policy 5.3 sets for the procedures relating to the storage and expiration dates of medications, biologicals, syringes and needles. PROCEDURE... 3. (3.3) Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors." On 11/8/2021 at 4:16 PM, an observation of Registered Nurse (RN #1) revealed the nurse left the cart unlocked and unattended in the hallway while giving the medications and performing a finger stick blood glucose test in a residents room. On 11/8/2021 at 4:28 PM, an observation of RN #1 revealed the nurse prepared the insulin dose for a resident and left the medication cart unlocked and unattended in the hallway while administering the insulin in a residents room. On 11/8/2021 at 4:37 PM, an observation of Licensed Practical Nurse (LPN) #2 prepared an insulin dose for a resident and left the medication	F 761	F761 -The center addressed the corrective action for those residents found to have been affected by the deficient practice by the Director of Nursing and Assistant Director of Nursing immediately checking all medication carts and med rooms to assure all were secured and locked on 11/8/21. A match back was performed the Director of Nursing and Assistant Director of Nursing on 11/8/21 to account for all medications. Education was provided by the Director of Nursing for Registered Nurse # 1 and Licensed Practical Nurse # 2 on 11/8/21 that included they should never leave their medication cart unlocked and unattended. -The center identified that any residents in the center has potential to be affected by this deficient practice. -To avoid recurrence of the deficient practice, the facility implemented systemic changes that included inservicing by the Director of Nursing initiated on 11/8/21 and completed on 11/12/21 that included proper storage and securing of medications in locked carts whenever unattended to all Registered Nurses and Licensed Practical Nurses. -The center plans to monitor the performance of the systemic changes to make sure the solutions are sustained by the Director of Nursing, Assistant Director of Nursing, or Registered Nurse Supervisor conducting rounds ensuring nurses are locking the medication/treatment carts when unattended daily for two weeks beginning	

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F 761	Continued From page 7 cart unlocked and unattended in the hallway while administering the insulin in a residents room. 0 11/08/2021 at 4:45 PM, an interview with RN #1 revealed that when she walks away from a medication cart the computer and the medication cart should be locked and that she had failed to lock her medication cart both times that she entered the residents room. On 11/8/2021 at 5:00 PM, an interview with LPN #2 revealed she always tries to lock her medication cart before walking away, but that she had noticed she left it unlocked when she came back to the medication cart and she stated, "It must have been my nerves that I forgot to lock my cart." On 11/9/2021 at 2:15 PM an interview with the Director of Nurses (DON) revealed the medication carts should always be locked when the nurse walks away from the cart, a wandering resident could get in an unlocked cart.	F 761	on 11/29/21, three times weekly for two weeks, then monthly for two months. Any negative findings will be corrected immediately and addressed with one on one inservicing and/or the center's progressive discipline policy. Findings will be brought to the center's Quality Assurance Performance Improvement meeting by the interdisciplinary team monthly beginning December 20, 2021 meeting for two months then as deemed necessary by the center's Quality Assurance committee.¿ Date of Completion: 12/20/21	
F 880 SS=F	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	F 880		12/20/21

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F 880	Continued From page 8 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions 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.	F 880		

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F 880	Continued From page 9 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review and facility policy reviews the facility failed to prevent the possible spread of infection as evidenced by failure to conduct hand hygiene during meal tray distribution, properly clean and sanitize a medication cart, an ice scoop and glucometers on four (4) of (4) hallways. Residents number #63, #77, #92,,#95, and #98 and two (2) residents observed during medication pass. Findings Include: Record review of a facility policy titled, "Handwashing/Hand Hygiene," with an effective date March 2020 revealed "POLICY This center considers hand hygiene the primary means to prevent the spread of infection. POLICY INTERPRETATION AND IMPLEMENTATION ... 2. All team members shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other team members, residents, and visitors ...5. Use an alcohol-based hand rub or, alternatively, soap (antimicrobial or non-antimicrobial) and water for	F 880	F880 -Corrective action for each resident identified in the deficiency involved the Director of Nursing assessing each resident on 11/7/21, including #98, #77, #92, #63 and on 11/8/21 including #6, #31, #57, and #95 to assure they had not experienced any negative effect of the deficient practice. No signs of infection were noted. The Director of Nursing and Assistant Director of Nursing circulated with all Certified Nursing Assistant staff to instruct them on the correct procedures to serve meal trays and ice in accordance with our hand hygiene and infection control policies on 11/7/21 and 11/8/21. The Director of Nursing, Assistant Director of Nursing, and/or Director of Clinical Education went to all nurses and educated them regarding the correct procedure for cleaning glucometers and sanitizing the medication carts. Completion date of 11/8/21.	

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F 880	Continued From page 10 the following situations ...b. Before and after direct contact with residents ...." Observation of evening meal on 11/07/21 at 5:25 PM, observed Certified Nursing Assistant (CNA) #4 on hallway A distributing the meal trays to the resident's in their rooms. CNA #4 set up a meal tray for Resident #98 and exited the room without using hand hygiene. CNA #4 then went to the food cart and removed the meal tray for Resident #77 and went into the room and set her meal tray up . CNA #4 then removed the dome lid from the tray and opened up resident's silverware and went to resident's dresser to retrieve a straw for the resident. CNA #4 touched the straw with her bare hands and placed in into the resident's drink glass. CNA #4 then exited the resident's room without using hand sanitizer or washing hands and went back to the food cart and retrieved the food tray for Resident #92, then walked into his room and placed his tray on his over the bed tray table and exited his room without using hand hygiene. CNA #4 then returned to the meal cart and obtained a food tray for Resident #63 and placed the tray down on the resident's over the bed tray table, walked to the window to close the window blinds for the resident and exited the room without any hand hygiene or hand sanitizer. CNA #4 then returned to the food cart and took another tray and the State Agency (SA) stopped the CNA and interviewed her regarding infection control and conducting hand hygiene after touching items on the food tray and in the resident's room without washing her hands or using hand sanitizer. The CNA stated that she had washed her hands earlier and that she had forgotten to use hand sanitizer or to wash her hands and confirmed that she should have after she exited each residents room before retrieving	F 880	-The center identified other residents having the potential to be affected by this deficient practice as being those residents receiving blood sugar readings via the glucometer. All residents receiving meal trays have the potential for being affected by poor hand hygiene during meal service. All residents receiving ice during ice pass have the potential for being affected by the poor handling of the ice scoop. Completion date of 11/08/21 -Immediately after learning of the deficient practices the Director of Nursing, Assistant Director of Nursing, and the Director of Clinical Education (Infection Preventionist) conducted visual rounds on 11/7/21 and 11/8/21 to ensure employees were practicing proper hand hygiene with meal tray service and ice delivery and performed education with nurses present regarding the proper procedure for performing a blood glucose check. The center will ensure the deficient practices of failure to comply with hand hygiene and proper sanitation will not recur by conducting a Root Cause Analysis with assistance from the Infection Preventionist, Quality Assurance Committee and Governing body by 11/29/21. Additionally, the Director of Clinical Education and Administrator will assure that staff complete training on Infection Prevention and Control with emphasis on Hand Hygiene and Sanitation from online infection prevention training courses offered by the Centers for Disease Control and Prevention. These courses will begin on 11/29/21 and completed by 12/7/21. If for some reason	

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	255102	A. BUILDING _____ B. WING _____	11/10/2021

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F 880	Continued From page 11 a meal tray for another resident. She stated that her failure to provide hand hygiene could possibly lead to the spread of infection. CNA #4 confirmed that the facility had provided in-services and that she knew better and just forgotten to clean her hands. Interview with the Director of Nursing (DON) on 11/10/21 at 2:50PM, confirmed that all of the staff are in-serviced constantly on hand hygiene and the importance of using hand sanitizer or washing their hands after contact with the residents to prevent the spread of infection from one resident to another. Record review of in-service dated 03/01/21 and signed by CNA #4 revealed that "Handwashing is done before and after each resident contact. Sanitizer can be used instead of soap and water when hands are lightly soiled without visible debris on hand. Hands are rubbed together until completely dry." Record review of the facility policy titled, "Equipment and Department Cleaning/Maintenance Policy" with an effective date April 2020 revealed under "POLICY Equipment is to be cleaned and maintained according to manufacturer's instructions. POLICY INTERPRETATION AND IMPLEMENTATION Each piece of equipment used for patient/resident care is to be cleaned with center approved surface disinfectant before	F 880	an employee cannot complete the online course in this timeline the center will not allow the employee to work until completion has been achieved. Completion date of 12/7/21 -The center plans to monitor its performance to ensure that the above solutions identified in Bullet Three are sustained by requiring the center□s Infection Control Preventionist, Administrator, Director of Nursing, Assistant Director of Nursing, or Registered Nurse Supervisors to monitor for compliance beginning on 11/29/21 by making infection control rounds to ensure proper hand hygiene practices are being followed during meal distribution, ice pass, and guidelines are being followed appropriately during blood glucose checks. Management will monitor staff daily for two weeks beginning on 11/29/21, three times weekly for two weeks, then weekly for four weeks. The center has developed a monitoring tool to capture the infection control monitoring rounds to assure corrective action is evaluated and sustained. This plan of correction was been implemented on 11/29/21 and integrated into the Quality Assurance system as evidenced by addressing the deficient practice and improvement plan in the Quality Assurance Performance Improvement meeting on 11/29/21. Any deficient practice noted during these monitoring rounds will be immediately corrected through one-on-one inservicing and/or the center□s progressive disciplinary policy and brought to the Quality Assurance Performance	

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F 880	Continued From page 12 and after each patient use. This includes, but not limited to: wheelchairs, blood pressure cuffs, glucometers, temperature probes, lifts, all therapy equipment, shower chairs, bedside table, and scales ...Each piece of equipment should be cleaned with disinfectant wipe on (Formal Name of Facility) formulary or product that is purchased from an approved list of EPA registered disinfectants. The manufacturer's instructions should be reviewed carefully for dry time after cleaning and before next use ...Equipment should not be used between patients without being appropriately disinfected ...The ice scoop is to not be left in the ice while not being used and should be cleaned daily in the dish machine..." Record review of the "Maintenance" instructions for the Assure Platinum blood glucose mete ,page 47, revealed "Cleaning and Disinfecting Guidelines..., Option 1: Cleaning and disinfecting can be completed by using a commercially available EPA (Environmental Protection Agency)-registered disinfectant detergent or germicide wipe.... Option 2: With all the recommended meter cleaning and disinfecting method, it is critical that the meter be completely dry before testing a resident's glucose level. Please follow the disinfectant product label instructions to ensure proper drying time..." On 11/8/2021 at 11:38 AM, an observation of Licensed Practical Nurse (LPN) #1 cleaned the glucometer after performing a fingerstick for Resident #31 revealed she cleaned her hands with hand gel, opened her medication cart and got out a sani-cloth from a purple top container and preceded to wipe the glucometer. LPN #1 wiped the glucometer for 30 seconds and then set it on a tissue on the medication cart to air dry.	F 880	Improvement meeting for review for two months. December Quality Assurance Performance meeting scheduled for December 20, 2021. Date of completion 12/20/21	

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F 880	Continued From page 13 On 11/8/ 2021 at 11:40 AM, an interview with LPN #1 revealed the nurses use sani-cloth purple top disinfectant wipes to clean the glucometers between each use. The State Agency (SA) asked what the kill time for the disinfectant wipe was and LPN#1 reported the kill time is two (2) minutes. The SA asked LPN #1 if she cleaned the glucometer for two minutes and she confirmed that she did not clean the glucometer for two minutes. LPN #1 then picked up the disinfectant wipe container and read the instructions and confirmed that the glucometer needed to stay wet for two minutes in order to kill viruses and bacteria. On 11/8/2021 at 4:16 PM, an observation of Registered Nurse (RN) #1 revealed the nurse after checking a residents blood sugar cleaned the glucometer using a purple top Sani Cloth wipe and wiped the glucometer for less than a minute and allowed it to air dry. On 11/8/2021 at 4:28 PM, an observation of RN #1 revealed the nurse after checking resident #57's blood sugar brought the glucometer out of the resident's room, sat it on the medication cart without utilizing a barrier, retrieved a sanitizer wipe out of the purple top Sani Cloth container and wiped the glucometer for 18 seconds and then laid the glucometer down on a tissue to air dry. RN #1 did not disinfect the top of the medication cart after placing the glucometer back in her medication cart. She confirmed she should have wiped the top of the medication cart. On 11/08/2021 at 4:45 PM, an interview with RN #1 revealed she used the purple top sani cloth to clean glucometers most of the time. When asked	F 880		

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F 880	Continued From page 14	F 880		

what the facility policy was for cleaning/disinfecting multiple resident use equipment such as glucometers, blood pressure cuffs, stethoscope, or pulse oximeters she replied she did not know the policy, but she always wiped them off with the purple top sanitizer wipes. The SA asked RN #1 to read the instructions on the purple top Sani Cloth disinfectant wipes, then asked what was the contact time for sani cloth to disinfect and RN #1 replied two minutes and she confirmed that she did not leave it wet for two minutes.

On 11/8/2021 at 4:12 PM, an observation was made of Certified Nurses Assistant (CNA) #1 exiting out of Resident #95's room with an empty ice scoop in his hand and he then placed the ice scoop in the ice cart in the hallway.

On 11/8/2021 at 4:37 PM, an observation of LPN #2 performed a finger stick blood glucose for Resident #6 and brought the glucometer back to the medication cart and sat the glucometer on top of the medication cart, washed her hands and placed a sani cloth over the top and sides of glucometer and did not wrap to the back of glucometer and allowed it to remain wet for two minutes.

On 11/8/2021 at 5:00 PM, an interview with LPN #2 revealed she normally wraps the glucometer with the sani-cloth all the way around the glucometer after cleaning the surface and confirmed that she failed to do that while cleaning the glucometer after she checked the blood glucose.She confirmed that her failure to appropriately clean the glucometer could spread infection.

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F 880	Continued From page 15	F 880		

On 11/8/2021 at 5:10 PM, an interview with CNA #1 revealed that he goes into a residents room, removes their lid to the residents ice cup, uses hand gel to disinfect his hands and then comes to the ice cart scoops ice in the ice scoop and then takes it into the room to fill the ice cup and then returns the ice scoop to the ice cart. The SA asked if CNA #1 disinfects the ice scoop before returning to ice cart and he replied that no one has ever told him that was a problem. CNA #1 reported that the RN supervisor told him to pass ice this way.

On 11/9/2021 at 2:15 PM, an interview with the Director of Nurses (DON) revealed the CNA's pass ice every shift, they are not supposed to take the ice scoop into the residents rooms. The SA asked what should be done to any equipment that goes from room to room, resident to resident she replied that such equipment would be disinfected between each resident use.

On 11/09/2021 at 3:30 PM, an interview with RN #2 who is the Supervisor for 3 to 11 shift revealed that CNA #1 came to her and asked if he should take the cup out of the room to pass ice and she told him that she did not take the cup out of the room because she didn't want to risk transferring bacteria and she left the conversation at that with CNA #1. She reported to SA that when she passes ice, she would fill a disposable cup with ice at the ice cart and take it into the room to pour it in the resident's ice cup. When asked did she instruct CNA #1 in the way she passed ice and she replied, "I did not".