STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355091	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLEY MEDICAL CENTER NURSING HOME	612 CENTER AVE N ASHLEY, ND 58413

(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 standard Medicare/Medicaid recertification started on 03/12/18 and concluded on 03/15/18.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.15), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 1 of 1 supplemental resident (Resident #22). Failure to accurately complete Section N (Medications) of the MDS, does not allow the assessment to accurately reflect the resident's current status/needs, and has the potential to affect the development of a comprehensive care plan and the care provided to the resident. Findings include: SECTION N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2017, page N-7, ". . . N0410H, Opioid: Record the number of days an opioid medication was received by the resident at any time during the 7 day look-back period (or since admission/entry or reentry if less then 7 days). . . ." Review of Resident #22's medical record	F 641	F 641 Accuracy of MDS It is the policy of the Ashley Medical Center to ensure that the MDS assessment accurately reflects the resident□s status. Information on the MDS must be coded following the guidelines established in the CMS Long Term Care Facility Resident Assessment Instrument User□s Manual for completion of the MDS 3.0. 1. A modification was completed on Resident #22 for item N 0410H to code for resident receiving Opiod medication 7 days. The modification was submitted to the CMS QIES and North Dakota Department of Human Services on 3-15-18. 2. The facility has determined that all residents have the potential to be affected. All items must be coded on MDS accurately for all residents in the facility in accordance with CMS guidelines. 3. MDS Coordinator reviewed medication lists of all residents in the facility and	4/19/18

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

Electronically Signed | 04/05/2018

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F 641	Continued From page 1 occurred on March 14, 2018. The physician's order identified, ". . . Norco [Hydrocodone-Acetaminophen] Tablet 5-325 mg [milligram]. Give 1 tablet by mouth two times a day related to chronic pain syndrome. . . ." A quarterly MDS, dated 02/05/18, identified staff coded Section N0410H Opioids; as 0. Review of the Medication Administration Record (MAR) for the 7 day look-back period, showed Resident #22 received Norco twice daily. During an interview on 03/14/18 at 4:15 p.m., the MDS coordinator (#4) confirmed staff failed to accurately code Section N0410H: Opioids on Resident #22's quarterly MDS.	F 641	compiled a listing of all residents that receive Opiod medications on scheduled or prn basis. This will be updated ongoing by MDS Coordinator and used as a reference tool when coding MDS items in Section N. 4. The MDS Coordinator will conduct a random audit of five (5) residents weekly x 4 weeks, biweekly x 3, monthly x 3 and quarterly x 3. The MDSs will be reviewed to ensure that any Opiod medication received during a reference period was coded on the MDS under Section N0410H. Responsible party: MDS Coordinator.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		4/19/18

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F 657	Continued From page 2 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure staff revised the comprehensive care plan to reflect the current status for 3 of 12 sampled residents (Resident #16, #21, and #27). Failure to revise the care plan to reflect Resident #16's oxygen needs and Resident #21 and #27's restorative goals/interventions limited the staff's ability to communicate needs and ensure continuity of care for residents. Findings include: Review of the facility policy titled "CarePlans/Conferences" occurred on 03/14/18. This policy, revised November 2017, stated, ". . . Additional focuses may be created to meet individual resident care area needs . . . The development, implementation, and maintenance of a resident's plan of care is an interdisciplinary process. . . ." - Review of Resident #16's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and a stroke. The current care plan stated, ". . . I usually have my Oxygen on whenever I'm in my room . . . I usually	F 657	F 657 Review/Revision of Care Plans It is the policy of the Ashley Medical Center that care plans must accurately reflect the care needs, preferences and Provider□s orders for the resident. 1. Restorative Aid program was added to the care plans of Resident□s #21 and #27. This was completed on 3-14-18. 2. The facility has determined that all residents that receive Restorative Aid have the potential to be affected. All care plans must accurately reflect the resident□s current care needs and Provider□s orders. 3. The Restorative Aid Department maintains a current list of all residents receiving a restorative aid program and receives new orders or changes in restorative aid orders from the Physical Therapist. The MDS Coordinator uses this list as a reference to enter the restorative aid program on the care plan. The Physical Therapist was educated on the importance of entering a provider order for restorative aid as a second	

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F 657	Continued From page 3 put on my own Oxygen when I enter my room and take it off when I leave. . . ." A physician's order, dated 01/05/18, stated, "02 [oxygen] continuously due to hypoxia at rest and with activity. Keep at 2L/min [2 liters per minute] per nasal cannula." During an interview on the afternoon of 03/14/18, a nurse manager (#2) confirmed the care plan failed to match the physician's order. The care plan failed to address the resident's current order for continuous oxygen. - Review of Resident #21's medical record occurred on all days of survey. Diagnoses included weakness and right foot drop. The medical record identified the following: * Restorative note dated 02/03/18 at 7:20 p.m.., "Receives RA [restorative assistant] for pulley exercises and LE [lower extremity] ROM [range of motion]. Participates well with pulley exercises, refuses LE ROM. Continues to make decision on when he wants to participate with exercises. Will continue to offer." * Task form for March 2018 stated, "Task: ADL [activities of daily living] - RA - Lower Extremity Range of Motion." * Task form for March 2018 stated, "Task: ADL - RA - Pulleys 4-6 times per week." Observation on 03/13/18 at 9:03 a.m. showed Resident #21 used the pulley arm exerciser in the doorway of his room. During an interview on 03/12/18 at 9:03 a.m., Resident #21 stated he uses the pulleys in his	F 657	reference for verifying accuracy on care plans. Education was provided on 4-10-18. The MDS Coordinator reviewed the care plans of all residents that receive restorative aid to ensure that any restorative aid regimen is present on all care plans. Review was completed by MDS Coordinator on 3-15-18. 4. The MDS Coordinator will conduct a random audit of five (5) residents that receive restorative aid weekly x 4 weeks, biweekly x 3, monthly x 3 and quarterly x 3. The care plans will be reviewed to ensure that restorative aid regimen is addressed on the care plan. Responsible party: MDS Coordinator. 1. The Oxygen order was changed by the Provider from continuous to as needed for shortness of breath for Resident #16. The care plan was revised to accurately reflect the current order for Oxygen. This was completed on 3-29-18. 2. The facility has determined that all residents that receive Oxygen have the potential to be affected. All care plans must accurately reflect the resident□s current care needs, including the Provider□s orders for Oxygen. 3. The MDS Coordinator reviewed the care plans of all residents that receive Oxygen to ensure that the care plans accurately	

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F 657	Continued From page 4 room for arm strengthening but is not doing any leg exercises at this time. Review of Resident #21's care plan failed to address a restorative therapy program. - Review of Resident #27's medical record occurred on all days of survey. Diagnosis included Alzheimer's disease and depression. The medical record identified the following: * 02/03/18 at 8:00 p.m., "Restorative Program Note: Participates very well with RA program for walking on days she is awake and alert." * 8/21/2017 at 8:28 a.m., "Restorative Program Note: Continues to participate in RA for walking. Participation fluctuates depending on sleepiness vs wakefulness. Walks very well with RA on days she is alert. No changes recommended." * Task form for March 2018: "Task: ADL - RA - Ambulation 4-6 times per week." Review of Resident #27's care plan failed to address a restorative therapy program. During an interview on 03/14/18 at 3:05 p.m., an administrative nurse (#4) confirmed that Resident #21 and Resident #27's restorative therapy program was not care planned.	F 657	reflect the Provider□s order for Oxygen. This was completed by MDS Coordinator on 3-29-18 4. The MDS Coordinator will conduct an audit to monitor that care plans of all residents receiving Oxygen accurately reflect the Oxygen use as ordered by the Provider. Study will be completed weekly x 4, biweekly x 3, monthly x 3 and quarterly x 3. Responsible party: MDS Coordinator	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 658		4/19/18

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F 658	Continued From page 5 Based on observation, record review, review of professional reference, and staff interview, the facility failed to follow professional standards of practice during 1 of 1 observation of administration of a blood pressure medication for Resident #18. Failure to carry out physician's orders regarding blood pressure parameters before administering a blood pressure medication may result in inadequate monitoring and adverse drug effects related to their use. Findings include: Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., Massachusetts, page 68, stated, ". . . Carrying Out a Physician's Orders . . . It is the nurse's responsibility to seek clarification of ambiguous or seemingly erroneous orders from the prescriber. . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . ." Observation on 03/14/18 at 8:50 a.m. showed a medication aide II (MAII) (#3) administered Losartan 50 milligrams (mg) to Resident #18. Review of Resident #18's physician's order for Losartan 50 mg, dated 06/16/17, stated, "Hold if BP [blood pressure] below 100/70." Review of Resident #18's vital signs showed the last blood pressure had been taken on 03/12/18, two days prior to the above observation. During an interview on 03/14/18 at 2:00 p.m., a staff nurse (#7) identified a physician's order, dated 07/17/17, to "d/c [discontinue] all blood	F 658	F-658 Services Provided Meet Professional Standards 483.21(b)(3)(i) 1. Immediate actions taken for the residents found to have been affected include: Immediate action(s) taken for the resident #18 that was found to be affected include immediate review of the resident□s medication orders parameters. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents with order parameters have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: A new policy/procedure for monitoring orders with parameters will be developed. The nurses will be educated on the new policy/procedure. Nurses will be educated on the entering of new orders with parameters. CMA□s will be educated on where to find the parameters prior to giving the medication. They will have an in-service on this and the new policy on 4/17/18. All other resident□s orders were reviewed to ensure all parameters are being followed. All residents□ orders will be included in quality assurance monitoring to assure reliable processes for the proper and consistent provision of physician ordered services. 4. How the corrective action will be	

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F 658	Continued From page 6 pressures." The order failed to specify if this included the blood pressure prior to the Losartan administration. The staff nurse (#7) then discontinued the blood pressure parameter for the Losartan without clarifying the order with Resident #18's physician. During an interview on 03/14/18 at 3:00 p.m., a nurse manager (#2) identified staff had failed to correctly enter the order for the blood pressure parameter for the Losartan, and the parameter order failed to appear on the electronic medication administration record (eMAR). The nurse manager stated nursing staff should have clarified the order with Resident #18's physician before discontinuing the blood pressure parameter. The facility failed to correctly enter, follow, and clarify Resident #18's physician orders.	F 658	monitored to ensure the practice will not recur: The ADON or DON will complete audits of all new admission orders to review resident medication orders with parameters to ensure that they are entered and followed correctly. The audits will be conducted weekly X 4 weeks, biweekly X 3, monthly X 3 and then quarterly X 3. Responsible party: DON/ADON	
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 observation, record review, and staff interview, the facility failed to provide oxygen for 1 of 3 sampled residents (Resident #16) with orders for continuous oxygen. Failure to ensure	F 695	F-695 Respiratory/Tracheostomy Care and Suctioning 483.25(i) 1. Immediate actions taken for the residents found to have been affected	4/19/18

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F 695	Continued From page 7 Resident #16 was provided continuous oxygen per physician order may result in increased shortness of breath and other respiratory conditions. Findings include: Observation on the morning of 03/13/18 showed Resident #16 ambulated from the dining room to his room without oxygen. Staff failed to offer or encourage the resident to use oxygen while ambulating. Observation on 03/13/18 at 1:55 p.m. showed a restorative aide (#7) ambulated Resident #16 down the hallway utilizing a platform walker. Staff failed to offer or encourage the resident to use oxygen while ambulating. Review of Resident #16's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease (COPD), cerebral infarction (stroke), and altered mental status. Review of the current care plan stated, ". . . I do have COPD and use Oxygen and inhalers. I usually have my Oxygen on whenever I'm in my room. . . . I usually put on my own Oxygen when I enter my room and take it off when I leave. . . ." The care plan failed to reflect the current physician orders for continuous oxygen use. Resident #16's physician's order, dated 01/05/18, stated, "02 [oxygen] continuously due to hypoxia at rest and with activity. Keep at 2L/min [2 liters per minute] per nasal canula." During and interview on 03/14/18 at 2:00 p.m., a	F 695	include: The order for continuous oxygen was changed to oxygen 2L/NC prn for COPD, SOB. Resident #16 does not need oxygen continuously. Oxygen must be assessed every shift by the nurses to determine the need for oxygen. The prn oxygen assessing was added to our policy/procedure. Our policy states that if a resident has an order for continuous oxygen, oxygen should be supplied at all times. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents who are on oxygen have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: If a resident has an order for continuous oxygen, oxygen should be supplied at all times. If continuous oxygen is no longer needed, the provider will be notified. If any change in oxygen is needed, the provider will be notified. All residents who do not need continuous oxygen will have an order of oxygen prn. Oxygen must be assessed every shift by the nurses. The prn oxygen assessing was added to our policy/procedure. All staff will have an in-service on 4/17/18 to educate on the charting all oxygen orders, and the new policy/procedure. 4. How the corrective action will be monitored to ensure the practice will not	

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F 695	Continued From page 8 nurse manager (#2) verified staff failed to follow the physician's order for continuous oxygen. Staff failed to offer/encourage Resident #16 to utilize his oxygen while ambulating.	F 695	recur: All residents charts with an oxygen order will be audited by the DON or ADON to make sure the providers order is being followed ensuring the proper oxygen administration is provided. The audits will be conducted weekly X 4 weeks, biweekly X 3, monthly X 3 and then quarterly X 3. Responsible party: DON/ADON	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		4/19/18

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F 761	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to store medications properly for 1 of 1 medication refrigerators. Failure to store medications in a safe environment may result in reduced effectiveness of medications. Findings include: Review of the facility policy titled, "Temperature of Refrigerators and Freezers" occurred on 03/15/18. This policy, revised 02/16/16, stated, ". . . Refrigerator temperatures shall be within the acceptable range 30 to 45 degrees F [Fahrenheit]. . . . At any time any refrigerator or freezer is not within the acceptable range it must be reported to environmental services immediately." A tour of the medication room occurred on 03/14/18 at 3:13 p.m. with an administrative nurse (#2). The medication refrigerator contained two thermometers. Both thermometers displayed a reading of 48 degrees F confirmed by the facility nurse. A reading of the medication refrigerator on 03/15/18 at 8:27 a.m. identified both thermometers with a reading of 46 degrees Fahrenheit. During an interview on 03/15/18 at 8:29 a.m., a facility staff nurse (#7) stated that night staff monitor the medication refrigerator temperatures and should notify staff of any concerns.	F 761	F-761 Label/store Drugs and Biologicals 483.45(g)(h)(1)(2) 1. Immediate actions taken include: One of the thermometers was taken out of the med fridge to assure accuracy of readings. SNF med fridge policy/procedure was revised to match the hospital policy/procedure which states: The temperature of the refrigerator that is used for the storage of medications will be kept in the range of 35 degrees F to 46 degrees F. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents who need medication from the refrigerator have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All nursing staff, CMA's and maintenance will have an in-service on 4/17/18 to update them on the revised policy/procedure on the temperature control log to ensure that is being done correctly. The Medication refrigerator policy was changed to state: The nurse or CMA will record the temperature on a daily basis on day shift. If the temperature is not within normal limits the temperature control nob will be adjusted and will be documented on the temperature control log. The nurse will adjust the temperature	

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F 761	Continued From page 10 Review of the facility "Temperature Control Sheet" occurred on 03/15/18. This form stated, "Refrigerator temperatures shall be within the acceptable range of 30 to 45 degrees F [Fahrenheit]. If not report to environmental services." The form identified temperatures taken from 11/19/17- 03/14/18. Temperature readings identified the following: * All temperatures were taken between 12:00 a.m. (midnight) and 6:00 a.m. * During the dates of 11/19/17 - 03/14/18, the medication refrigerator temperature readings were documented at 46 degrees 24 times and 48 degrees three times. * There were no temperatures documented between 01/05/18 and 01/09/18. During an interview on 03/14/18 at 5:00 p.m., an administrative nurse (#2) stated nursing staff should be reporting temperatures above 45 degrees F to maintenance and administration. During an interview on 03/15/18 at 8:55 a.m., a facility maintenance staff member (#9) stated facility staff have reported no concerns with the medication refrigerator temperatures.	F 761	if it falls below 35 degrees F or above 46 degrees F. If this does not correct the problem by the next day, maintenance will by notified to repair or replace the fridge. The nurse will document action taken on the temperature control log. 4. How the corrective action will be monitored to ensure the practice will not recur: The ADON or DON will audit the fridge temps weekly X 4 weeks, biweekly X 3, monthly X 3 and then quarterly X 3. Responsible party: DON/ADON	
F 880 SS=E	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	F 880		4/19/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355091	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 11 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions 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	F 880		

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F 880	Continued From page 12 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy/procedure, and staff interview, the facility failed to follow infection control practices during 1 of 1 observation of glucometer cleaning. Failure to practice infection control related to cleaning of the glucometer has the potential for transmission of communicable diseases and infections to residents and staff. Findings include: Review of the facility policy titled "Blood Sugar Check with One Touch Ultra" occurred on 03/15/18. This policy, dated May 2013, stated, ". . . Cleanse the glucose machine with Cavi wipes. DO NOT use alcohol or other solvent to clean the meter. Machine must be sanitized between each patient/resident use with Cavi wipes."	F 880	F-880 Infection Control 483.80(a)(1)(2)(4)(e)(f) 1. Immediate actions taken for the residents found to have been affected include: The CMA identified was immediately in-serviced on the proper procedures for glucometer disinfection, including wet time. Our policy was changed to clean the glucometers with hydrogen peroxide wipes. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents requiring finger stick glucose	

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F 880	Continued From page 13 Observation on 03/14/18 at 11:00 a.m. showed a medication aide II (MAII) (#3) cleaned the OneTouch Ultra glucometer with a Hydrogen Peroxide wipe after completion of a resident's blood glucose test. The MAII wiped off the glucometer and placed it back in the basket in the medication cart. The Hydrogen Peroxide wipe's container identified certain time frames, from 30 seconds to 5 minutes, to let the device stay wet in order to disinfect for various bacteria and/or viruses. During an interview on 03/14/18 at 3:00 p.m., a nurse manager (#2) agreed the glucometer needed to stay wet for a certain time frame, and the facility policy stated Cavi-wipes should have been used to clean the glucometer. The facility failed to appropriately disinfect the glucometer after resident use.	F 880	monitoring have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Per manufacturers master label on the Hydrogen peroxide wipes, it is clarified that they are safe to use on the glucometers. CMA□s/Nurses will use 2 glucometers when checking blood sugars to ensure the wet time between residents is 5 minutes. The glucometer will be cleaned after each resident use and the other glucometer will be used for next resident. The nurses and CMA□s will have additional training on the new policy/procedure for cleaning of the glucometers including observation while performing the procedure on 4/17/18. 4. How the corrective action will be monitored to ensure the practice will not recur: The ADON or DON will complete audits of the CMA□s/Nurses performing glucometer disinfection to ensure they are performing per new policy/procedure. The audits will be conducted weekly X 4weeks, biweekly X 3, monthly X 3 and then quarterly X 3. Responsible party: DON/ADON	