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	355069	A. BUILDING _____ B. WING _____	04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND CARE CENTER	620 14TH AVE NE DEVILS LAKE, ND 58301

(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 For the standard Medicare/Medicaid recertification survey started on 04/14/14 and completed on 04/16/14, the sample included four (4) residents for complete review, nine (9) residents for focused review, and three (3) closed records for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278	1. Resident #10 has had a modified assessment completed and it was sent on 5/2/14. - Admission MDS assessment dated 01/06/14 sections J1700 and N0410 were modified and resent. 2. Any resident having an MDS assessment completed has the potential to be affected by the deficient practice. 3. Our facility already has processes in place to ensure proper documentation on the MDS. Refer to both Exhibit A and B. Information regarding last fall and antidepressant was located on both exhibits. We will not be changing any	5/19/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karissa Olson
TITLE: Administrator
(X6) DATE: 5-20-14

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 278	Continued From page 1 material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to complete a Minimum Data Set (MDS) assessment which accurately reflected the resident's status for 1 of 13 sampled residents (Resident #10) with coding related to falls and the use of antidepressant medication. Failure to accurately code the MDS for Resident #10 limited the facility's ability to develop and implement an individualized care plan consistent with the resident's needs and functional status and may affect the level of care provided to the resident. Findings include: The Long-Term Care Facility RAI User's Manual (Version 3.0), October 2013, pages J-27 and J-28, stated "J1700: Fall History on Admission . . . Steps for Assessment . . . 1. Ask the resident and family . . . about a history of falls in the month prior to admission and in the 6 months prior to admission. . . . 2. Review inter-facility transfer information (if the resident is being admitted from another facility) for evidence of falls. 3. Review all relevant medical records received from facilities where the resident resided during the previous 6 months . . . Coding Instructions for J1700A, Did the Resident Have a Fall Any Time in the Last Month Prior to Admission . . . Coding Instructions for J1700B, Did the Resident Have a Fall Any Time in the Last 2-6 Months prior to	F 278	policies at this time. Re-education will be given to both MDS Coordinators regarding using tools already in place including the RAI manual when working on the MDS assessments. - Psychotropic medications are located in residents MAR which are to be reviewed on all assessments for proper coding of section N0410 on the MDS. Information is also received from prior health care settings for review on all new or readmissions. - MDS Coordinators have been instructed to review inter-facility transfer information and to obtain and review relevant medical records from facilities where the resident resided during the previous 6 months per RAI manual guidelines section J1700 Steps for Assessment. - Education done the week of 5/5/14-5/9/14 with MDS coordinators consisted of	

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F 278	Continued From page 2 Admission . . ." The Long-Term Care facility RAI User's Manual, (Version 3.0), October 2013, page N-4 and N-5, stated "N0410: Medications Received . . . Coding Instructions . . . N0410C, Antidepressant: Record the number of days an antidepressant medication was received by the resident at any time during the 7-day look-back period (or since admission . . .)" - Review of Resident #10's medical record occurred on April 14-16, 2014. Resident #10's hospital history and physical, dated 12/25/13, prior to admission to the facility, stated, ". . . she did fall but had no major injury. . . ." A physician visit, dated 02/07/14, stated "Previously she had been at [name of an assisted living facility]. Because of her instability and falling, it was not felt she could return . . ." The admission MDS, dated 01/06/14, failed to identify, in section J1700A and J1700B, Resident #10's fall history on admission. - Current medications listed for Resident #10 included mirtazapine (Remeron), an antidepressant medication. The medical record identified a physician order for mirtazapine on 12/30/13. An admission MDS, dated 01/06/14, failed to identify the antidepressant medication. During interview on the afternoon of 04/16/14, an administrative nursing staff member (#5) confirmed the inaccuracy of Resident #10's MDS related to fall history and use of an antidepressant medication on admission.	F 278	review of sections J and N on the MDS and current tools in place when coding of the MDS. 4. Cynthia Perrault, RN, RAC-CT, RAC-MT, Senior Consultant for Pathway Health Services will be conducting random audits of MDS assessments 5/5/14 – 5/9/14. She will also be doing additional education for both MDS coordinators. - Director of Nursing will do random audits of the MDS assessments on a bimonthly basis for 2 months then monthly for 4 months starting the week of 5/19/14. Results of audits will be reviewed quarterly at next QA meeting scheduled for 7/17/14. 5. Re-education will be provided to both MDS Coordinators per Director of Nursing by 5/9/14.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 3 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the necessary care and services to manage behavioral symptoms for 1 of 1 sampled resident (Resident #8) with dementia who received an as needed (PRN) antipsychotic medication. Failure to identify target behaviors, assess the reason/causative factor(s) for behaviors, implement appropriate interventions (including non-pharmacological interventions), and establish accurate on-going monitoring of the behaviors has the potential to prevent this resident from obtaining her highest practicable physical, mental, and psychosocial well-being. Findings include: - Review of Resident #8's medical record occurred on April 14-16, 2014. Diagnoses included Alzheimer's disease, reactive psychosis, impulse control disorder, depression, and dementia with behavioral disturbances. A quarterly Minimum Data Set, dated 01/24/14, identified severe cognitive impairment, constant inattention and disorganized thinking, verbally abusive one to three days, wandered daily, and daily use of an antipsychotic and antidepressant. Current medications included sertraline HCL	F 309	1. Resident #8 PRN Seroquel has been discontinued as of 5/5/14 as she has not used it in approximately 1 month. 2. Any resident on PRN psychotropic medications has the potential to be affected by this deficient practice. 3. Resident #8 PRN Seroquel was missed and proper documentation sheet was not put into behavior monitoring binder. Nurse Manager and Director of Nursing will review all psychotropic medications and make sure proper documentation sheets are in the Behavior Monitoring binders. Facility will also have medical records notify Nurse Manager of any new orders obtained for psychotropic medications. Education will be given to the nurses on proper documentation and documenting interventions prior to administering PRN psychotropic medication. They will also be educated on notifying the Nurse Manager	5/20/14

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F 309	Continued From page 4 (hydrochloride) (an antidepressant) 75 milligrams (mg) daily, Seroquel (an antipsychotic) 50 mg twice a day, and Seroquel 12.5 mg every six hours PRN for agitation. The current care plan for Resident #8 stated, "Problem, Behavior/Wanders: Resident wanders in the facility without thought to safety. May wander into other resident's rooms. Resident becomes upset at others and yells out. Family indicates that she has a long history of paranoia and feels others are stealing her belongings. Her family also indicates that she hides things to 'protect' them, then doesn't recall and thinks they are stolen. . . . Approaches: Approach in a calm manner. Be consistent gentle, & [and] firm while setting limits. Assist to BR [bathroom] PRN. Direct attention to another activity. Remove from problem areas when able. Redirect from others as needed if resident is upset. Visit one on one to redirect thoughts of paranoia." The current care guide, posted in Resident #8's room, stated, "Encourage activities, magazines, sorting papers." Review of the PRN Medication Administration Record (MAR), from December 1, 2013 to April 16, 2014, identified Resident #8 received PRN Seroquel on 11 occasions when staff failed to attempt non-pharmacological interventions prior to administering the PRN Seroquel. During interview on 04/16/14 at 11:00 a.m., administrative nurses (#5 and #9) confirmed staff are to document non-pharmacological interventions attempted prior to the administration of a PRN dose of Seroquel. The medical record lacked evidence facility staff	F 309	of any new orders obtained for psychotropic medications. - Director of Nursing and Nurse Manager review all behavior monitoring sheets for all residents receiving psychotropic medications on a monthly basis. Target behaviors and effectiveness of medications are reviewed at that time. During monthly review DON and Nurse Manager discuss need for dose reductions/increases or discontinuations. Information is then reviewed with resident's primary medical doctor or psychiatrist for recommendations. 4. Interdisciplinary team will review all PRN psychotropic medications given along with the behaviors at scheduled IDT meetings to ensure proper documentation. If documentation is lacking, nurses involved will be re-	

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F 309	Continued From page 5 attempted non-pharmacological interventions prior to the administration of the PRN Seroquel and failed to consistently identify/document the actual behavior exhibited by Resident #8 that resulted in the administration of the medications. Failure to identify the specific behavior, patterns, trends, and monitor for effectiveness may lead to use of unnecessary medications and ineffective management of Resident #8's behaviors.	F 309	educated by Nurse Manager or designee. - Psychotropic drug reports are reviewed on a monthly basis and quarterly at QA meetings. Next QA meeting is scheduled for 7/17/14. Interdisciplinary team has already reviewed PRN psychotropic drug use starting 5/7/14 and will continue weekly for the next 6 months. 5. Medical Records will start to notify Nurse Manager of new psychotropic medications effective 5/7/14. Education will be given to the Nurses at mandatory meetings on 5/19 and 5/20/14. Education will be given by Director of Nursing. Director of Nursing and Nurse Manager will review all psychotropic medications by 5/16/14.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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, record review, policy and procedure review, and staff interview, the facility failed to provide the necessary assistance with activities of daily living (ADLs) for 1 of 1 (Resident #2) male resident who required assistance with perineal care. Failure to provide perineal cares may result in skin irritation/breakdown. Findings include: Review of the facility's policy titled "Pericare for the Resident" occurred on the morning of 04/16/14. The policy, dated 06/04/10, stated, " Pericare (or perinial [sic] care) involves cleaning the genital and anal areas of the body. To decrease or prevent urinary tract infections, to prevent odor, and to provide comfort and	F 312		

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F 312	Continued From page 6 cleanliness for the resident. . . ." Review of Resident #2's medical record occurred on April 14-16, 2014. Diagnoses included dementia and chronic kidney disease. Resident #2's current care plan stated, ". . . Res. [resident] unable to toilet self secondary to requiring assist with transfers and toileting tasks. . . . Extensive assist of 2 and Hoyer lift for transfers onto the commode and extensive assist of 1 to use the urinal and for pericares. . . ." Observation on 04/15/14 at 10:05 a.m. showed two Certified Nursing Assistants (CNAs) (#1 and #2) assisted Resident #2 to use the commode. The resident was incontinent of urine. The CNA (#2) cleansed the resident's buttocks with a wipe, but failed to provide frontal perineal care. Observation on 04/15/14 at 3:05 p.m. showed two CNAs (#3 and #4) assisted Resident #2 to use the commode. The resident was incontinent of urine. The CNA (#4) cleansed the resident's buttocks with a wipe, but failed to provide frontal perineal care. During an interview on 04/16/14 at 7:55 a.m., an administrative nursing staff member (#5) confirmed staff should clean the front perineal area as well as the back during perineal cares.	F 312	1. Nurse Manager verbally educated involved CNA's during the survey process after information was received. 2. Any resident that is requiring assistance with toileting has the potential to be affected by the deficient practice. 3. The facility Standards of Care Policy and Procedure has been updated to include #11 – 'Cleansing wipes may be used for routine toileting cares. Perineal cares to be completed on residents requiring assistance with toileting after all toileting.' (Exhibits C & D).	5/21/14
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323	4. CNA's will be educated on proper perineal care along with review of the updated Standards of Care policy and procedure. Perineal care audits are currently being done on	

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F 323	Continued From page 7 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy and procedure review, and staff interview, the facility failed to use interventions as care planned to prevent injury for 1 of 1 sampled resident (Resident #2) and 1 of 1 closed record resident (Resident #14). Failure of facility staff to follow Resident #14's care plan regarding transfers resulted in a laceration requiring sutures; and increased the risk for injury/falls for Resident #2 and all residents using a chair alarm. Findings include: Review of the facility's policy titled "Fall Management" occurred on the afternoon of 04/16/14. The policy, dated 04/25/13, stated, "Certified Nursing Assistants 1. Follow the intervention as outlined on the care plan. . . ." - Review of Resident #14's medical record occurred on 04/16/14. Medial diagnoses included dementia. The care plan stated, ". . . requires assist with ADLs . . . transfer [assist] of [two] [with] hoyer lift, dated 09/04/13 . . ." Review of Resident #14's nurses' notes identified the following: *09/08/13, 1:00 a.m. - "At 1932 [7:32 p.m.] this nurse was called to memory care unit regarding occurrence with resident. Further staff notified for assist, Res [resident] resting in bed on her left side, large 8 cm [centimeters] laceration noted to	F 323	random residents requiring assistance with toileting on a monthly basis, which will continue. (Exhibit E) - Perineal care audits will be done bimonthly for 3 months and then monthly for 3 months. Audits will be reviewed on a monthly basis by Director of Nursing for any further education required. 5. Education will be given per Director of Nursing on 5/21/14 during a mandatory CNA meeting. Audits will continue per Nurse Manager or designee.	

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F 323	Continued From page 8 RLE [right lower extremity] anteriolateral aspect. Scant bleeding noted. Area cleaned and dry dressing applied to keep area clean and prevent further injury . . res would be transported via ambulance for evaluation and treatment. . . ." *09/08/13, 10:00 a.m. - "changed drsg [dressing]. Frank amt [amount] of drng [draining] to bandages. 4 sutures in place lg [large] area of exposed tissue. cleansed [and] hydrogel applied [with] sterile gauze wrapped [with] kling. Tylenol given as scheduled." Review of the investigation report, on 04/16/14, identified Resident #14's leg "got caught on the bed frame" during a two person assist with a gait belt transfer into her bed. Further review of the facility's investigation results indicated the staff that transferred Resident #14 with the gait belt knew that her care plan identified she is a Hoyer lift only transfer. During an interview on 04/16/14 at 11:55 a.m., an administrative nursing staff member (#6) stated staff used a two person assist with a gait belt to transfer Resident #14 on 09/08/13 and should have used a hoyer lift. - Resident #2's current care plan stated, " . . . Dementia with balance, mobility and cognitive deficits. HX [history] of falls resulting in a L) [left] hip fracture. Resident attempting to stand from bed and from w/c [wheelchair] frequently . . . Recent fall resulting in R) hip fx [fracture] . . . Bed and chair alarms, dated 03/11/14, ..." Resident #2's nurses' notes identified the following fall from a wheelchair resulting in a right hip fracture: *03/06/14,7:45 a.m. - "Writer and CNA [certified	F 323	Part 1: resident #14 1. Resident #14 is no longer in facility. 2. Any resident that requires assistance with transfers has the potential to be affected by the deficient practice. Upon notification of incident, education was given immediately to the CNA's involved on 9/9/13. 3. There will be no changes in policy and procedure. Investigation was completed on 9/9/13 and sent to the North Dakota Department of Health for review (exhibit F). Investigation concluded that both CNA's were aware of proper transfer technique. Resident Care Cards are located in all of the resident closets. Any changes made in the plan of care are communicated to staff via communication books located at all nurses stations. These interventions will continue. There continues to be a designated lift in the Memory Care Unit for staff to use. 4. Random audits of proper transfer techniques will be done on a bimonthly basis for 3 months and monthly for 3 months. Audits will be reviewed by Director of Nursing on a monthly basis. 5. Staff educated and disciplined at time of incident and Director of Nursing will review importance of following the plan of care during mandatory CNA meeting on 5/21/14. Part 2: resident #2 1. Resident #2 chair alert was placed on chair on 4/16/14 once information was given to Nurse Manager.	5/21/14

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F 323	Continued From page 9 nursing assistant] responded after hearing crash in room. Upon entering w/c laying on its back. . . . Res c/o [complained of] right groin pain. No obvious deformities. ROM [range of motion] impaired during abduction . . .Res unable to do further assessing due to pain level." *03/06/14, 7:50 a.m. - "Notified ambulance need for transfer." *03/06/10:00 a.m. - "Received [sic] [and] observed order to send to [name of hospital]. Dx [diagnosis] R) Femoral hip fx." Observations completed April 14-16, 2014 showed Resident #2 seated in his wheelchair with no chair alarm in place. Failure to follow Resident #14's care plan resulted in injury requiring medical intervention. Failure to follow the care plan for Resident #2 may increase the risk of falls/injury.	F 323	2. Any resident requiring an alarm is at potential risk for deficient practice. Currently 9 residents have alarms and all are in place. 3. Residents with alarms have all been audited and are in place, completed 5/5/14, per Director of Nursing. All residents with wheelchairs will have a device card placed on their wheelchair indicating what type of cushion, alarm, positioning device, etc. Resident Care Cards will continue to be located in each resident room closet for easy staff access. Alarms will be placed in resident TAR's for nurses to sign off each shift by 5/21/14. 4. Random alarm audits will be done on all residents with alarms on a weekly basis for 1 month, bimonthly for 1 month, then monthly for 4 months. Audits will be conducted by Nurse Manager or designee (exhibit G). Immediate staff education will take place as needed for any discrepancies in plan of care. Audits will be reviewed by Director of Nursing monthly. 5. Device cards and audits will be implemented by 5/21/14. Nurses will be educated 5/19/14 and 5/20/14. CNA's will be educated on 5/21/14 at mandatory meetings per Director of Nursing. Nurse Manager will be education by 5/6/14 of changes implemented per Director of Nursing.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		

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F 441	Continued From page 10 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and staff interview, the facility failed to follow infection control standards for 2 of 2 observed dressing changes (Resident #4 and #6) and for 1 of 3 observations of glucose monitoring (Resident #17). Failure to follow infection control standards during dressing changes and glucose monitoring may result in contamination and exposure of bloodborne pathogens to residents and staff. Findings include: Review of the facility's dressing change procedure occurred on 04/16/13. This undated procedure stated, ". . . 8. Remove old dressing (if	F 441	Part 1: Dressing Changes 1. Nurse was verbally re-educated on 4/16/14 as soon as information was received per Nurse Manager. 2. Any resident requiring dressing changes has the potential to be affected by the deficient practice. 3. There will be no changes in policy and procedure at this time as Infection Control Standard Precautions are already in place and accurate. (exhibit H: Hand Hygiene and Gloves) 4. Facility will continue Hand Hygiene Audits months (exhibit I) and will increase our Dressing Changes Audits (exhibit J) to bimonthly for 3 months and monthly for 3 months. Nurse Manager or designee will educate immediately during audits as needed. 5. Audits will be done per Nurse Manager or designee starting	5/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. BUILDING _____ B. WING _____	04/16/2014

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F 441	Continued From page 11 present), both primary and secondary dressing should be gently removed to avoid trauma to the wound and periwound skin. 9. If the secondary dressing is adhesive, gently lift the edge of the dressing and remove from the skin. If necessary, remover wipes may be used. Clean skin of remaining residue. 10. Dispose of the dressing and gloves properly. 11. Wash hands. 12 Put on a new pair of gloves. 13. Gently flush the wound by spraying wound cleanser (product name) into or on the wound. Be sure to address any undermining and tunneling areas as well. . . ." - Observation of a dressing change for Resident #6 occurred on 04/16/14 at 8:32 a.m. The nurse (#7) washed her hands, donned a pair of clean gloves and removed the dressing from Resident #6's foot. The nurse (#7) failed to remove the soiled gloves and wash her hands before cleansing and applying a new dressing to the pressure ulcer on Resident #6's foot. - Observation of a dressing change for Resident #4 occurred on 04/16/14 at 9:55 a.m. The nurse (#7) washed her hands, donned a pair of clean gloves and removed the dressings from Resident #4's right and left buttocks. The dressings were noted to be soiled with a small amount of drainage. The nurse (#7) failed to remove the soiled gloves and wash her hands before cleansing the wounds on Resident #4's buttocks. During interview on 04/16/14 at 2:20 p.m., an administrative nursing staff member (#5) stated the expectation would be to follow the standard of practice regarding changing gloves during a dressing change. - Observation of glucose monitoring for Resident	F 441	immediately after education given to Nurse Manager on 5/6/14. Nurses will be re-educated per Director of Nursing during mandatory nursing meetings 5/19/14 and 5/20/14. Part 2: Glucometers 1. glucometer located in her nurse server located in the Memory Care Unit. Nurses were reminded of this per Director of Nursing on 4/16/14. 2. Any resident that has weekly or monthly glucometer checks have the potential to be affected by the deficient practice as they do not have their own machine. The strips for glucometers outdate 4 months after opening. 3. There will be no changes in policy and procedure at this time as all residents with a daily glucometer check have their own glucometer. This was recently implemented	

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F 441	Continued From page 12 #17, on 04/15/14 at 4:27 p.m., showed the nurse (#8) failed to cleanse the glucose monitor after testing the resident's blood. The nurse then placed the glucometer into the glucometer carrying case. The nurse took the case to the treatment cart, removed the glucometer from the carrying case, cleansed the glucometer and placed the clean glucometer into the soiled carrying case. The facility labeled this glucometer for general use, with potential use for multiple residents. During interview on 04/16/14 at 11:00 a.m., administrative nurses (#5 and #9) confirmed the nurse (#8) should clean the glucometer at the point of use.	F 441	4/1/14 with all nurses educated on 3/18/14. 4. The facility will implement random Glucose Monitoring Audits (exhibit K) on a bimonthly basis for 3 months and then monthly for 3 months. Nurses will be educated immediately during audits as needed. Nurses will be re-educated during mandatory meeting per Director of Nursing. 5. Nurse Manager or designee will implement the Glucose Monitoring Audits after education given per Director of Nursing on 5/6/14. All nurses will be educated during the mandatory nurse meetings on 5/19/14 and 5/20/14.	