DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____ 3/19/10	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1551 BIG HORN AVE SHERIDAN, WY 82801

(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 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, review of resident council meeting minutes, and staff, resident, and family interviews, the facility failed to ensure bathrooms on 4 of 4 resident units were kept clean and sanitary. In addition, the facility failed to maintain cleanliness of a wheelchair seat belt. The findings were: 1. Observation in the secured unit (Courtyard) on 2/22/10 at 4 PM revealed the room of resident #27 smelled of urine and the floor was sticky. Further observation on 2/23/10 at 9:25 AM revealed the floor remained dull, sticky, and covered with footprints, and furthermore, the room still smelled of urine. During the 2/23/10 observation, registered nurse (RN) #7 stated the floor was sticky because the resident "urinates on it." She further stated the room had been mopped that morning, but after verifying the condition of the room and the odor, she requested that housekeeping re-mop it. At 10:30 AM that day, housekeeper #8 confirmed he had mopped the floor twice that morning, but the urine smell remained. Furthermore, observation at that time showed the floor remained dull and sticky, and footprints were still visible. The housekeeper stated he had deep scrubbed the floor a few days ago, but the odor returned. Interview with certified nurse aide (CNA) #2 on 2/23/10 at 1:07 PM revealed the resident had been urinating on the	F 253	Preparation and/or execution of the response and plan of correction does not constitute admission or agreement by the provider of the Truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state Law. For the purpose of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual. **TAG F-253 – PLAN OF CORRECTION** **Corrective Date:** 3/18/10 **Corrective Action:** All bathrooms and commodes on the 300 hallway were cleaned and disinfected. **Identification of Others:** Audit of all Bathrooms in the facility was completed and identified issues were remedied. **Systems/Measures:** 1. In-service of all housekeeping staff to ensure proper cleaning and disinfecting procedures are followed on a daily basis will be completed 3/18/10. 2. Housekeeping to complete daily rounds of bathrooms for cleanliness. 3. Ambassador rounds done daily by IDT to observe for any concerns.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David Conaway — TITLE: administrator — (X6) DATE: 03/17/10

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: GKE911 Facility ID: WY0028 MAR 19 2010 If continuation sheet Page 1 of 15

This POC accepted E changes & corrections per phone conversation E Jean Stevenson, DON, & Betty Nelson RN Health Surveyor on 3/19/10 @ 1628.

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F 253	Continued From page 1 floor since his/her admission in December 2009. 2. Confidential interviews with non-sample residents on 2/23/10 and 2/24/10 revealed dirty bathroom floors and commodes were cited by four of eight (50%) of the residents interviewed. These residents stated "...dirty floors, dirty corners [of the bathroom floor], and urine on/around commodes..." were not always cleaned by housekeeping personnel on the Chapel, Sunrise, and Deer Lane units. Review of resident council meeting minutes showed that for three of the last six months residents complained of dirty bathrooms. This information was documented in meeting minutes dated 10/22/09, 1/8/10, and 2/8/10. 3. Interview with an unidentified family member on 2/22/10 at 4:00 PM revealed the family member visited the resident three or four days a week. The family member stated the resident's bathroom commode had been dirty with dried feces and urine spills, and dirt and debris had been clustered along the floor baseboard of the bathroom for the past two weeks. The family member further stated that s/he had to clean the resident's walker last week because there was dried feces on the handle bars. 4. Periodic observations on 2/22/10 and 2/23/10 showed the wheelchair seat belt fastened around the waist of resident #67 was crusted with dried food and crumbs.	F 253	**Monitoring:** Data obtained by way of rounds will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by the Housekeeping Manager/designee. The QA&A committee will evaluate the Effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly x 3.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores	F 314	**F-314** **Corrective Date:** **Corrective Action:** Resident # 64 was assessed and all interventions in place were placed on TAR and Restorative Charting Sheets.	**3/18/10**

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F 314	Continued From page 2 does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy and procedure review, and medical record review, the facility failed to accurately assess risk factors and consistently implement effective pressure sore prevention measures for 1 of 8 residents (#64) who developed facility acquired pressure sores. The findings were: Review of the care plan for resident #64, updated on 2/18/10, showed the resident's risk factors for developing pressure sores included diabetes, impaired sensory perception, decreased activity, impaired diffuse/localized blood flow, and a prior history of pressure sores. Further review showed interventions included completing a full body skin check weekly and applying a foot cradle and blue heel protectors when the resident was in bed. Review of the 2/18/10 skin/wound interdisciplinary team note showed staff identified a stage II pressure sore on the resident's left heel on 1/20/10. According to that note showed the pressure sore had deteriorated "this week," and was red with a slight foul odor and sero-sanguineous drainage. The pressure ulcer was documented as measuring 0.5 centimeters (cm) x 0.6 cm x 0.3 cm. Review of the physician order sheet dated 2/22/10 showed the physician's prescribed an antibiotic for the infected pressure sore and repeat wound culture tests after the	F 314	**Identification of Others:** All at risk residents were assessed. No further issues identified. **Systems/Measures:** 1. All nursing staff will be in-serviced on proper execution of pressure wound prevention protocols and interventions by 3/18/10. 2. Pressure prevention interventions will be placed on MAR's, TAR's and Restorative charting sheets and Programs to ensure they are charted on daily. **Monitoring:** Restorative Nurse and Unit Managers will audit MAR's, TAR's and Restorative sheets and programs weekly x 3 months. The results of these audits will be reported to the DON and to the facilityQA&A committee by the Unit Managers or DON/designee. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly x 3.	

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F 314	Continued From page 3 antibiotics were completed. Observation of the pressure sore on 2/24/10 at 10 AM with the registered nurse #3 confirmed the appearance of the pressure sore was as described by the interdisciplinary team on 2/18/10. On 2/24/10 at 2:15 PM, when asked about the facility's system for preventing the development of avoidable pressure sores, the wound care nurse stated the facility's system for preventing the development of avoidable pressure sores included a weekly skin assessment and a quarterly Braden scale assessment (a tool used for predicting pressure sore risk). She also stated that the documented information on the assessments was completed by the staff nurses and used in the process of determining the most appropriate preventive skin care interventions. The following concerns related to failure to implement the facility's skin management program were identified: a. Observation on 2/23/10 at 1 PM revealed the resident was resting in bed without heel protectors. b. Review of the quarterly Braden Scale assessments dated 8/12/09 and 11/03/09 showed this resident's risk was mild; however, the assessment remained unchanged on 1/21/10 (the day after the pressure sore was identified). Interview with the wound care nurse on 2/24/10 at 2:30 PM verified the Braden assessments were inaccurate for 11/3/09 and 1/21/10. c. Review of the medical record showed the resident had a pressure sore on 1/20/10, but the weekly skin assessment documentation on the treatment record showed the resident did not have a pressure sore on 1/24/10 or 1/31/10. Interview with the wound care nurse on 2/24/10 at 2:30 PM verified the inaccurate assessments. d. During the 2/24/10 interview, the wound	F 314		

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F 314	Continued From page 4 care nurse stated that a foot cradle and heel protectors were implemented as preventive measures for the resident when s/he developed the pressure sore that healed in April 2009. The wound care nurse commented that she had personally observed the resident in bed without the heel protectors or the foot cradle. She stated the facility lacked a system for ensuring staff consistently implemented these interventions. She further stated the lack of a monitoring system made it difficult to determine whether the pressure sore developed as a result of inconsistent implementation of the heel protectors and foot cradle or whether the interventions were implemented, but ineffective. Review of the facility's skin care policy and procedure entitled "Skin Management Guidelines," revised March 2008, showed the following guidelines were included. a. The small vessel disease that often accompanies diabetes puts the resident at a greater risk of damage from pressure. b. Accurate evaluations of the resident's pressure sore risk factors and monitoring and evaluating the impact of the interventions must be clearly documented in the clinical record. c. The nurse should assure that treatment interventions, care plan and the appropriate skin documentation records are initiated in a timely manner,.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315	F-315: **Corrective Date:** **Corrective Action:** Resident # 64 Was re-assessed and a new toileting plan was implemented.	3/18/10

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F 315	Continued From page 6 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure appropriate care and services to address urinary incontinence was provided for 1 of 7 sample residents (#64) with bladder incontinence. The findings were: Review of the 1/21/10 significant change Minimum Data Set assessment for resident #64 showed the resident occasionally had episodes of bladder incontinence and required extensive assistance with toileting. Review of the care plan, updated on 2/1/10, showed interventions for incontinence included a voiding schedule before and after meals and at bedtime. Continuous observation on 2/23/10 from 7:40 AM until 10:35 AM (almost three hours) revealed the resident self-propelled a wheelchair to his/her room after breakfast and remained in the wheelchair until 10:35 AM. During that time staff did not ask the resident if s/he needed to use the toilet or offer toileting assistance or check the resident for incontinence. During an interview at 8:30 AM, the resident stated sometimes staff "could not get" to him/her in time and s/he had "accidents," but the resident "tried not to let it bother" him/her. At 10:35 AM certified nurse aide (CNA) #5 and licensed practical nurse #9 removed the resident's urine-soiled disposable brief and provided toileting assistance. Interview with the CNA at the time of the observation revealed staff	F 315	**Identification of Others:** All other residents were monitored. No further issues identified. **Systems/Measures:** 1.By 3/18/10 all nursing staff will be in-serviced on proper follow through of toileting programs and the necessity of informing Restorative Nurse of any changes in residents' ability to communicate need to toilet and/or changes in continence. **Monitoring:** The Restorative Nurse/designee will continue to monitor incontinence levels on all residents quarterly and will re-assess any residents with changes. All residents will be re-assessed annually regardless of changes. The results of this monitoring will be reported to the DON and to the facility QA&A committee by the Restorative Nurse/designee. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly x 3.	

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F 315	Continued From page 6 did not routinely assist the resident with toileting after meals. During an interview on 2/24/10 at 5:50 PM, the director of nursing stated staff should follow the resident's care plan.	F 315		
F 323 SS=E	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 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and labeling information, the facility failed to ensure a safe environment for residents in 1 of 3 activity rooms. The findings were: Observations on 2/22/10 at 4:48 PM, 2/23/10 at 2:30 PM, 2/24/10 at 8:11 AM, and 2/25/10 at 11:13 AM revealed an activity room with a door opening into one of the main corridors. The door to that activity room remained open during the observations. All residents except those in the special care unit had access to the room. Four cabinets were observed in the room. One of the four cabinets had a padlock attached to the door, but the lock was not being used. The following 3 items were identified in the unlocked cabinet: a. One 16 fluid ounce bottle of 3% hydrogen peroxide topical solution. Review of the bottle label showed "If swallowed get medical help or contact a poison control center immediately." b. One 24-ounce container of Zip Foaming	F 323	F-323: **Corrective Date:** **Corrective Action:** The cabinet in the ADL Room was locked. **Identification of Others:** All other cabinets and carts in the facility containing cleaning supplies or hazardous materials were checked. No further issues identified. **Systems/Measures:** 1. All staff will be in-serviced regarding proper secured storage of cleaning supplies or hazardous materials by 3/18/10. 2. Activity Director/designee will perform a daily audit of the cabinet in the ADL Room containing cleaning supplies or hazardous materials for the next 3 months. **Monitoring:** Data obtained by way of these audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by the Activity Director/designee. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly x 3.	3/18/10

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F 323	Continued From page 7 Glass Cleaner. According to the label on the bottle, the contents should be used "only as directed. Misuse can be harmful or fatal, contains 2-butoxyethanol." c. One quart bottle of VIREX disinfectant cleaner. The instructions on the bottle label read, "contact poison control center in the event of eye or skin contact, contains dimethyl benzol ammonium chloride." In addition, one pair of scissors and several nail clippers were also found in the closet. Interview with the director of nursing on 2/25/10 at 11:13 AM revealed the closet should be locked when staff are not present in the room.	F 323		
F 441 SS=E	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. (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	F 441	F-441: **Corrective Date:** 3/18/10 **Corrective Action:** The nurse observed by the Survey Team was in-serviced on proper technique for drawing up injectables. The Dietary manager has been in-serviced on proper isolation and hand-washing techniques with return demonstration. **Identification of Others:** All nurses are identified at risk to improperly draw up injectables. No other staff identified at risk for violation of isolation/hand-washing procedures. **Systems/Measures:** 1. By 3/18/10 all staff will be in-serviced on the proper technique	

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F 441	Continued From page 8 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. (o) 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, staff interview, and review of medical records, infection control policies and procedures, and infection surveillance logs, the facility failed to ensure staff complied with posted infection control precautions when delivering food trays for 1 of 2 meal observations. The facility further failed to ensure staff followed safe injection practices to prevent the transmission of infections to residents. The findings were: A. Regarding compliance with infection control precautions: 1. Dietary staff were observed delivering food trays to the Sunrise Lane unit on 2/22/10 from 5:40 PM through 5:56 PM. The dietary manager (DM) entered the room of non-sample resident #5 at 5:46 PM to deliver a meal. This room was posted with contact precautions signage that required all staff to wash hands before entering the room and again prior to exiting. A large isolation cart was positioned directly outside the	F 441	for drawing up injectable medications. 2. Return demonstrations were performed by all nurses in-serviced. 3. On 3/15/10 Dietary Manager received and participated in 1:1 in-service on proper Isolation/hand-Washing protocol. **Monitoring:** Random audits of nurses drawing up medication in syringes will be conducted by the SDC weekly. Data obtained by way of these audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by the SDC/designee. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly x 3.	

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F 441	Continued From page 9 room, providing personal protective equipment (PPE) such as gloves, gowns, shoe covers, and masks for staff use. The 16 minute observation revealed the following deficient practices: a. The DM failed to wash her hands before entering the room and did not use any PPE to minimize her exposure risk or prevent transmission of an infectious agent to other residents. While in the room, the DM was observed to place her hands on high-touch surfaces (counter top adjacent to a hand washing sink, bedside table). She did not wash her hands prior to exiting the posted room or prior to resuming food tray delivery. b. The DM next entered an adjacent room to deliver a food tray to non-sample resident #6. While in this room, the DM repositioned the resident's bedside table and assisted the resident to reposition by moving his/her bed covers. The DM also placed her hands on several high-touch surfaces, including the counter top adjacent to a sink and a privacy drape around the resident's bed. c. After attending to the resident's meal and positioning, the DM washed her hands at the resident's sink. However, the hand washing process lasted less than 4 seconds from turning on the water to drying her hands; the scrubbing phase was less than 2 seconds, and no suds were observed on the employee's hands prior to rinsing. 2. The infection control practitioner (ICP) stated in interview on 2/24/10 at 1:10 PM that resident #5 was placed on contact precautions because s/he tested positive for Clostridium difficile toxin. Review of the resident's medical record on 2/24/10 at 3:25 PM showed laboratory reports confirming C. difficile and nursing notes instituting	F 441		

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SHERIDAN MANOR	1851 BIG HORN AVE SHERIDAN, WY 82801

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F 441	Continued From page 10 isolation protocols to prevent transmission of the pathogen to other residents. 3. The ICP further stated in the 2/25/10 interview at 9:15 AM that the facility followed the current (October 2002) hand hygiene guideline recommended by the Centers for Disease Control and Prevention (CDC). The CDC guideline recommends hands be scrubbed together vigorously for at least 15 seconds, covering all areas of the hands and fingers, before rinsing. The ICP added 'contact isolation' required that all persons must wash their hands, or use a hand sanitizing gel, when entering and exiting a posted room. B. Regarding safe injection practices: 1. On 2/22/10 at 5:29 PM, licensed practical nurse (LPN) #29 was observed preparing to administer insulin for resident #10. Prior to drawing air into the syringe during preparation of the insulin, the LPN placed her fingers on the plunger of the syringe instead of on the phalange, thus contaminating the inside of the syringe. The phalange is the enlarged area at the end of the plunger specifically made for holding the syringe when filling. The LPN then injected air into the vial of insulin. With her fingers again on the plunger, the LPN next drew the insulin into the contaminated syringe before returning the vial to a storage compartment for future use. The LPN then administered the insulin to the resident. 2. On 2/25/10 at 11:25 AM, the director of nursing confirmed that the insides of syringes were sterile and her expectation was that sterility of syringes be maintained. According to Elkin, Perry, and Potter "Nursing Interventions & Clinical Skills," 4th	F 441		

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F 441	Continued From page 11 Edition, 2007: one should "avoid touching" the plunger of a syringe. The CDC guideline for Safe Injection Practices to Prevent the Transmission of Infection to Patient, contained in their 2007 Isolation Precautions guideline, identifies aseptic technique (a set of "specific practices and procedures performed under carefully controlled conditions with the goal of minimizing contamination by pathogens") as a critical component of safe injection practices.	F 441		
F 467 SS=E	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide outside ventilation to 7 of 14 resident bathrooms on the southwest (Deer) unit. The findings were: During the facility tour on 2/24/10 between 11:30 AM and 2:10 PM the bathrooms in resident rooms #401, #404, #405, #408, #411, #412 and #415 did not have functional ceiling air vents. All bathrooms had a wall switch controlling the ceiling fan, but none of the fans worked. All bathrooms were interiorly located, i.e., they did not have exterior windows. Interview with the maintenance manager on 2/24/07 at 1:48 PM revealed he did not know why the ventilation system did not work. A retired maintenance manager was then contacted by the current manager. He stated the reason the	F 467	**F-467:** **Corrective Date:** **Corrective Action:** All air handlers that survey identified in resident bathrooms have been repaired. **Identification of Others:** An audit of all the air handlers that service resident bathrooms throughout the facility was completed and all identified issues were repaired. **Systems/Measures:** Maintenance Director and Maintenance assistants have been in-serviced on the importance of outside ventilation for resident bathrooms. Weekly preventive maintenance audits will be completed on air handlers to ensure compliance with standard. **Monitoring:** Maintenance director and/or designee will monitor for compliance. Data obtained by way of rounds will be reviewed and analyzed for patterns and trends and reported to the facility QA&A committee by the Maintenance Director/designee. The QA&A committee will evaluate the	3/18/10

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F 467	Continued From page 12 ventilation system did not work was probably because a belt on the roof mounted ventilation motor "was busted."	F 467	effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly x 3.	
F 503 SS=E	483.75(j)(1)(i-iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in Part 493 of this chapter. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter. If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of quality control records and glucometer (glucose testing device) operating instructions, the facility failed to ensure staff adhered to the manufacturer's requirements for performing quality control procedures on 4 of 4 glucometers sampled during survey. The findings were:	F 503	**F-503:** **Corrective Date:** 3/18/10 **Corrective Action:** Glucometer Control check procedure was obtained. **Identification of Others:** Audit was conducted and errors noted on all four units. **Systems/Measures:** 1. Proper protocol for Glucometer Control checks posted at all units. 2. In-service provided for all licensed nurses on proper protocol for Glucometer control checks by 3/18/10. **Monitoring:** Unit Managers will audit Glucometer Control Check sheets weekly and report results to DON. DON will audit Glucometer Control sheets monthly x 3. Data obtained by way of these audits will bereviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by the DON/designee. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly x 3	

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F 503	Continued From page 13 1. On 2/22/10 at 5:15 PM licensed practical nurse (LPN) #10 was observed performing a fingerstick glucose test on resident #29 in the secure unit. Following the test, the LPN stated she had to return the glucometer to the Chapel Lane unit; the device was borrowed because the glucometer in the secure unit "...was not working right..." Subsequent review of the current (February 2010) glucometer quality control logsheets on 2/23/10 disclosed the following deficient practices: a. None of the four resident units in the facility listed the acceptable range of quality control values on the control logsheets used by testing personnel; these values would be required to verify accurate glucometer performance. Interviews with each of the four unit supervisors on 2/23/10 revealed they were not aware control values were to be compared to an established range of results, nor did they know information on acceptable control ranges was printed on the label of each bottle of glucose reagent test strips. b. Referring to the manufacturer's acceptable quality control ranges for current lot numbers of reagent test strips, it was discovered the high level control used on Deer Lane exceeded the acceptable range of values on five of twenty-two days (23%). There was no evidence staff detected the out-of-range conditions or took corrective actions to ensure test accuracy. c. The Chapel Lane unit had out-of-range control values recorded for eight of twenty-two days (36%) on the high level control, and two additional days lacked documentation of any control procedures. There was no evidence to show staff were aware of the out-of-range conditions or multiple days of missing control data. d. Documentation from the Sunrise Lane unit	F 503		

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F 503	Continued From page 14 showed glucometer controls had not been tested for four of twenty-two days (18%) in the current month. There was no evidence to show staff were aware of multiple days without completion of quality control procedures. 2. The manufacturer's label affixed to each vial of reagent test strips and each bottle of control material contained an expiration date for the product and a statement that each product had a 90-day expiration once opened. None of the four opened vials of reagents test strips or eight bottles of opened control materials were dated by staff to show the correct 90-day shelf life. 3. The director of nursing stated in interview on 2/23/10 at 10:10 AM that she was not aware quality control values were to be compared with an acceptable range of values, nor was she aware that glucometers had been used when controls values were out-of-range. She added that 24 of 84 residents (29%) at the facility had current physician orders for routine glucose testing.	F 503		