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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00413234, IN00413534, IN00419669, IN00420386, and IN00420394. Complaint IN00413234 - No deficiencies related to the allegations are cited. Complaint IN00413534 - No deficiencies related to the allegations are cited. Complaint IN00419669 - Federal/State deficiencies related to the allegations are cited at F755, F759, F761, and F880. Complaint IN00420386 - No deficiencies related to the allegations are cited. Complaint IN00420394 - No deficiencies related to the allegations are cited. Survey dates: October 26, 27, 30, 31, and November 1, 2023 Facility number: 000032 Provider number: 155077 AIM number: 100273330 Census Bed Type: SNF/NF: 105 Total: 105 Census Payor Type: Medicare: 2 Medicaid: 94 Other: 9 Total: 105	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey conducted November 1, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of December 1, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gregory Otter	Executive Director	11/24/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 9, 2023.			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and			

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	periodically reconciled. Based on observation, interview, and record review, the facility failed to ensure medications were available, administered, and documented the disposition of controlled medications accurately for 2 of 11 residents observed for medication administration. (Residents JJ and D). Findings include: 1. During a random medication pass observation with Qualified Medication Aide (QMA) 16, on 10/31/23 at 11:55 a.m., Resident JJ's Floconazole 150 milligram (mg) (used to treat and prevent fungal infections) was observed to be highlighted in red on the electronic medication administration record (eMAR). QMA 16 indicated medications highlighted in red meant the medication was past due for the ordered administration time. A physician's order for Resident JJ, dated 10/27/23, indicated to administer Fluconazole 150 milligram (mg) give 1 tablet by mouth one time daily every 3 days for yeast infection until 11/3/23. During an interview on 11/1/23 at 12:42 p.m., the Director of Nursing Services (DNS) indicated, Resident JJ's Fluconazole had not arrived from the pharmacy until 10/31/23, the time frame for administration of the medication had to be reset. The resident record lacked documentation the facility back-up pharmacy had been contacted to timely obtain the medication. 2. During a random medication pass observation on 10/31/23 at 12:15 p.m., QMA 16 indicated Resident D's Oxycodone (narcotic analgesic) 5 mg was ordered to be administered 4 times daily at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m., but	F 0755	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident JJ's medication had been delivered by the pharmacy on 10/31/23. The NP was notified of the delay and the time frame for the medication was reset to account for the delay and ensure resident received the full course of treatment. Medication was administered as ordered and no adverse effects were noted. Resident D's medication was delivered by the pharmacy on 10/31/23. The NP was notified of the medication administration concerns. NP assessed resident on 10/31/23 and 11/1/23 and noted no complaints of pain. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** All residents were audited for current medications marked unavailable. No residents noted with unavailable medications. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All nurses and QMAs were	12/01/2023

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	the medication was not available because she needed a new script. QMA 16 was not observed to call the physician or retrieve the medication from the emergency drug kit (EDK - small quantity of medications available to dispense when pharmacy services were not available). A physician's order, dated 10/8/23, Oxycodone 5 mg give 1 tablet by mouth four times a day for pain. An October 2023 eMAR for Resident D, documented on 10/31/23 at 12:00 a.m. the resident refused medication, on 10/31/23 at 6:00 a.m. the resident refused, and a 2nd line indicated resident received her medication. At 12:00 p.m., and 6:00 p.m., the resident received her medication. On 11/1/23 at 9:00 a.m., observation of a new card of Oxycodone 5 mg for Resident D in the narcotic box, dated 10/31/23. A narcotic count sheet indicated 2 doses had been administer on 10/31/23 at 6:00 p.m. and 11/1/23 at 6:00 a.m. The DNS indicated, on the evening of 10/31/23 the times for administration had been changed from four times daily to two times daily. On 11/1/23 at 10:51 a.m., observation of an electronic EDK log for Resident D with Licensed Practical Nurse (LPN) 18 and the DNS. The log indicated 2 separate doses of Oxycodone 5 mg had been taken out on 10/31/23 at 3:35 a.m. and 10/31/23 at 9:52 a.m. LPN 18 indicated, although the order was 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m., the resident was not always available on the floor. During an interview on 11/1/23 at 12:47 p.m., the DNS indicated, when observing the eMAR medications highlighted white meant the		educated on the medication administration and general guidelines policy with concentration on, but not limited to, unavailable medications and physician notifications. - Education and training were provided to nurses and QMAs on 11/2/23 by the DNS. Education provided: Medication Administration and General Guidelines **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** DNS or Designee will audit 5 random residents for unavailable medications twice per week x4 weeks, then once per week x4 weeks, then once every other week x 4 weeks, then once per month x3 months. Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance.	

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	medication was not due, green meant the medication had been administered, yellow meant the medication was due to be administered, and red indicated the medication was past due. Medication times were set up on the hour, with a window of an hour either way to administer. When new medication orders were written it would automatically transmit to the pharmacy for the medication to be sent. Nurses were responsible for timely re-ordering medications using the eMAR and making sure they were available for administration. On 11/1/23 at 1:45 p.m., the Vice President of Clinical Services (VPCS) provided a Medication Administration and General Guidelines policy, dated 7/10/23, and indicated the policy was the one currently being used by the facility. The policy indicated, "Medications are administered in accordance with written orders of the attending physician...Medications are administered within one hour of the scheduled time ...If a dose of regularly scheduled medication is withheld, refused, or given at other that the scheduled time ...the space provided on the front of the MAR is for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record ...The physician must be notified when a dose of medication has not been given ..." This citation relates to Complaint IN00419669. 3.1-25(a)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its-			

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	§483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5% when staff failed to follow standard nursing principles and facility policy to prepare narcotic medication, and failed to ensure medications were administered on time for 2 of 11 residents observed for medication administration (Resident GG and PP). Findings include: 1. During a random medication pass on 10/31/23 at 11:42 a.m., Qualified Medication Aide (QMA)16 was observed to remove a Hydrocodone (narcotic analgesic) 10/325 milligram (mg) tablet from a locked narcotic box on the back hallway medication cart on hallway A for Resident GG. QMA 16 read the order from the electronic medication administration record (eMAR), found the medication bubble card in the narcotic box, popped the pill into a medication cup, and then Registered Nurse (RN) 17 took the cup of medication, walked down the hallway, and entered Resident GG's room. QMA 16 indicated, RN 17 would give the Hydrocodone to the resident after the nurse completed an assessment. QMA 16 was questioned three times to verify, and each time indicated the medication she had prepared would be administered by RN 17. QMA 16 was observed to electronically sign as having administered the medication on the eMAR. A physician's order for Resident GG, dated 7/18/23, Hydrocodone 10/325 mg give 1 tablet four times a day for pain. 2. During a random medication pass observation with QMA 19 on 11/1/23 at 10:10 a.m., Resident	F 0759	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident PP was assessed with no adverse effects noted. NP notified of administration timing. Resident GG's lidocaine patch was removed. NP and MD notified of patch removal timing. Resident assessed and no adverse effects noted. New order initiated to ensure clarity in time of removal. No adverse effects noted in relation to hydrocodone administration. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** 12 residents identified with transdermal patch orders. Audits initiated to ensure timely removal of patches. Orders initiated to ensure clarity in time of removal. All residents receiving medication may be affected by medication administration timing. Audits initiated to ensure timely administration of medication throughout the facility. Order administration timing reviewed with NP and medical director. All residents receiving medication may be affected by	12/01/2023

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	GG was overheard asking the QMA to remove a Lidocaine patch from her lower back so she could go take a shower. Resident GG indicated she showered every morning and then wanted her new patch put on afterwards. The resident indicated staff routinely removed the old patch before her shower in the am, not in the evening. QMA 19 could not answer as to why the evening staff would leave the medicated patch on the resident for longer than ordered. A physician's order indicated Lidocaine (medicated patch used to relieve nerve pain or help reduce itching and pain from certain skin conditions) 1% skin patch on in am, off in p.m. The resident record lacked documentation Resident GG routinely wore a Lidocaine 1% patch for approximately 24 hours versus removing at bedtime per physician's orders, assessment for possible side effects, or physician notification. 3. During a random medication pass observation with Registered Nurse (RN) 20, on 11/1/23 at 9:35 a.m., Resident PP's Acetaminophen 500 mg (analgesic and anti-inflammatory) with label instructions to give 2 tablets three times daily, was observed to be highlighted in red on the eMAR. RN 20 indicated the medication was ordered to be administered at 8:00 a.m., but staff passed meal trays at that time. During an interview on 11/1/23 at 12:47 p.m., the Director of Nursing Services (DNS) indicated when observing the eMAR medications highlighted red indicated the medication was past due. Medication times were set up on the hour, with a window of an hour either way to administer. Nursing staff were not allowed to set up a narcotic medications and have another nurse staff member		medications not prepped and administered by the same staff member. Audits initiated to ensure medications are prepped and administered by the same nurse/QMA. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All nurses and QMAs were educated on the medication administration and general guidelines policy with concentration on, but not limited to, timely administration of medication, appropriate removal of patches and physician notifications. - Education and training were provided to nurses and QMAs on 11/2/23 by the DNS. Education provided: Medication Administration and General Guidelines Transdermal patch administration and medication disposal Transdermal Medicated Patches Post-Test Medication Administration: Preparing and Administering Post-Test **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance**	

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	administer the mediation due to the need to verify for the correct resident, physician's order, and medication being administered. On 11/1/23 at 1:45 p.m., the Vice President of Clinical Services (VPCS) provided a Medication Administration and General Guidelines policy, dated 7/10/23, and indicated the policy was the one currently being used by the facility. The policy indicated, "Medications are administered in accordance with written orders of the attending physician...Medications are administered within one hour of the scheduled time ...Except for single unit dose packet distribution systems, only the licensed or legally authorized personnel who prepare a medication may administer it. This person then records the administration on the residents MAR at the time the medication is given ..." This citation relates to Complaint IN00419669. 3.1-25(b)(3) 3.1-25(b)(4) 3.1-25(b)(9) 3.1-25(b)(o) 3.1-48(a)(2)		**program will be put into place?** DNS or Designee will audit 5 administrations/disposals of transdermal medicated patches to ensure proper removal and disposal on random halls and shifts 2 times per week x4 weeks, then once per week x4 weeks, then once every other x4 weeks, then monthly x 3 months. Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance. DNS or Designee will audit 5 medication administrations for timeliness of administration on random halls and shifts 2 times per week x4 weeks, then once per week x4 weeks, then once every other x4 weeks, then monthly x 3 months. Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance. DNS or Designee will audit 5 medication passes to ensure medication is prepped and administered by the same nurse/QMA on random halls and shifts 2 times per week x4 weeks, then once per week x4 weeks, then once every other x4 weeks, then monthly x 3 months. Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance.	

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F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §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.			
	Based on observation, interview, and record review, the facility failed to ensure medications were stored properly in 1 of 2 medication carts observed on the A hallway (back hallway cart), and medicated patches were destroyed properly for 1 of 1 medication observed being destroyed (Residents B and GG). Findings include: 1. During a random narcotic count observation of	F 0761	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident GG's lidocaine patch was removed. NP and MD notified of delayed removal. Resident assessed and no adverse effects noted. New order initiated to ensure clarity in time of	12/01/2023

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	the back hallway medication cart on the A hallway, a medication bubble pack for Resident B of Zolpidem 1 milligram (mg) (sedative to treat insomnia) with labeled instruction to give 1 tablet at bedtime was observed to have 6 pills on the card; 5 in a row and 1 loosely taped onto the card on a separate row. Qualified Medication Aide (QMA) 16 indicated she had no answer as to who had taped the pill onto the back of the card or why. Physician's order for Resident B, dated October 2023, indicated the resident had no current order for Zolpidem. A second observation of a medication bubble pack for Resident B of Zolpidem 1 mg in the narcotic box on the back hallway medication cart on the A hallway with QMA 19. One of 6 pills continued to be loosely taped out of order onto the back of the package. On 11/1/23 at 12:47 p.m., the Director of Nursing Services (DNS) indicated Resident B was not currently taking Zolpidem and had no current physician's orders. The resident took the medication only when she was receiving chemotherapy (chemo) and staff kept the medication locked up for when the resident resumed chemo to prevent wasting her medications. DNS acknowledged taping a medication onto the back of a medication card was not good nursing practice as staff could not guarantee the identity or integrity of the meditation. 2. During a random medication pass observation with QMA 19 on 11/1/23 at 10:10 a.m., Resident GG was overheard asking the QMA to remove a Lidocaine patch from her lower back so she could		removal. No adverse effects noted in relation to hydrocodone administration. Resident B's taped medication was removed and destroyed. No adverse effects were noted. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** 12 residents identified with transdermal patch orders. Audits initiated to ensure timely removal of patches. All narcotic drawer's audited for taped medications. No taped medications identified. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All nurses and QMAs were educated on the Medication Storage Policy with an emphasis on transdermal patch removal and proper storage with no medications taped into medication cards. - Education and training were provided to nurses and QMAs on 11/2/23 by the DNS. Education provided: Medication Storage Policy Transdermal medicated patch administration and removal	

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	go take a shower. Resident GG indicated, she showered every morning and then wanted a new patch put on afterwards. Resident indicated staff routinely removed the old patch before her shower in the am, not in the evening. QMA 19 was observed to remove the medicated patch and dispose of it in an open trash can positioned at the end of the resident's bed near the divider curtain separating her from the roommate. A physician's order indicated Lidocaine 1% (medicated patch used to relieve nerve pain or help reduce itching and pain from certain skin conditions) skin patch on in a.m. and off in p.m.. On 11/1 23 at 10:15 a.m., when questioned QMA 19 indicated she should not have left the Lidocaine patch in the resident's room. She was observed to retrieve the patch and disposed of the patch in a clear trash bag tied onto the side of the medication cart. During an interview on 11/1/23 at 12:47 p.m., the DNS indicated, Resident GG's patch should have been discarded in the resident's trash can and left in the room. The patch when removed should have been placed in the resident's trash can, the trash bag removed, and the bag containing the patch carried to the soiled utility room to be disposed of. A medication destruction policy was not provided during the survey process. This citation relates to Complaint IN00419669. 3.1-25(j) 3.1-25(o)		Transdermal Medicated Patches Post-Test **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** DNS or Designee will audit 5 narcotic drawers to ensure proper storage with no medications taped into medication cards twice per week x4 weeks, then once per week x4 weeks, then once every other week x 4 weeks, then once per month x3 months. Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance. DNS or Designee will audit 5 administrations/disposals of transdermal medicated patches to ensure proper removal and disposal on random halls and shifts 2 times per week x4 weeks, then once per week x4 weeks, then once every other x4 weeks, then monthly x 3 months. Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance.	
F 0880 SS=E	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

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Bldg. 00	§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, 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:			

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	(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §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.			
	Based on observation, interview, and record review, the facility failed to ensure proper sanitation procedures of glucometers (instrument for measuring blood glucose concentration), and to ensure glucometers were not shared between residents to prevent possible cross contamination for 7 of 7 residents observed for blood glucose monitoring, to include a HIV (human immunodeficiency virus) positive resident (Residents FF, JJ, QQ, C, RR, SS, and TT).	F 0880	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All nurses and QMAs on shift were immediately educated on proper sanitation of glucometers. Glucometers for residents FF, JJ, QQ, RR, SS and	12/01/2023

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	Findings include: 1. During a random observation on 10/31/23 at 11:58 a.m., Registered Nurse (RN) 15 was observed to check the blood glucose level of 6 residents on the A hallway using a single glucometer (Residents FF, JJ, QQ, C, RR, and SS). RN 15 was followed going from one resident room to the next carrying a small plastic basket containing lancets, glucose strips, and 1 glucometer. After checking each resident's glucose levels by pricking their finger with a lancet, putting blood onto a glucose strip that was inserted into the glucometer, and obtaining the reading, the nurse would write down the reading on a piece of paper she was carrying, and then go to the next resident room. RN 15 was never observed to clean the glucometer before or after each resident use. The glucometer was laid among clean supplies in the basket. RN 15 indicated, she had checked 7 resident's glucose levels in the morning around breakfast time, and she had 6 residents to check at lunch time. RN 15 indicated glucometers were to be cleaned between resident use with alcohol preps. During an interview on 10/31/23 at 12:22 p.m. RN 15 indicated nurses and Qualified Nursing Assistants (QMA's) were allowed to check blood sugar levels with a glucometer. Only nurses were allowed to administer insulin. There were multiple glucometers stored in the front medication cart on the A hallway, but the glucometers were for multi-use and not assigned resident specific. RN 15 indicated there were no residents with an infectious communicable disease diagnoses. During an interview on 10/31/23 at 12:23 p.m., the		TT were immediately sanitized following appropriate procedure in the presence of DNS. Resident TT was immediately provided a separate glucometer labeled with resident name. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** 20 residents were identified with orders requiring blood glucose monitoring. Individual labeled glucometers were provided for each identified resident. Additional glucometers were made available on each unit to ensure immediate availability of a new glucometer when needed. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All nurses and QMAs were educated on Glucometer Cleaning and Storage with an emphasis on effectively sanitizing the glucometer and utilizing the appropriate dwell time to ensure efficacy. - Education and training were provided to nurses and QMAs on 11/2/23 by the DNS. Education provided: Glucometer Cleaning and Storage	

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	DNS indicated, there were multiple glucometers available in the medication carts, so nurses did not need to stop between residents and wait for the glucometers to dry between cleanings. 1a. Resident FF's record was reviewed on 11/1/23 at 10:30 a.m. Diagnoses on Resident FF's profile included type 2 diabetes mellitus with diabetic chronic kidney disease. A physician's order for Resident FF, dated 8/31/23, indicated check blood sugar before meals and inject Novolog FlexPen (rapid acting insulin) subcutaneous per sliding scale: if 0 - 199 = 0; 200 - 250 = 3; 251 - 300 = 4; 301 - 350 = 5; 351 - 400 = 6; 401 - 450 = 7, call physician if less than 70 or greater than 451. 1b. Resident JJ's record was reviewed on 11/1/23 at 10:50 a.m. Diagnoses on Resident JJ's profiled included type 2 diabetes mellitus. A physician's order for Resident JJ, dated 8/31/23, indicated check blood sugar before meals and bedtime, inject Lispro (fast-acting insulin) solution per sliding scale: if 151 - 200 = 1 unit; 201 - 250 = 2 unit; 251 - 300 = 3 unit; 301 - 350 = 4 unit; 351 - 400 = 5 unit, call physician if less than 70 or over 400. 1c. Resident QQ's record was reviewed on 11/1/23 at 11:15 a.m. Diagnoses on Resident QQ's profile included type 2 diabetes mellitus. A physician's orders for Resident QQ, dated 10/19/23, indicated check blood sugar in the morning, Metformin 1000 mg give 1 tablet by mouth twice daily, and Jenuvia 100 mg give 1 table by mouth in the morning for hyperglycemia (high blood sugar).		Competency for Blood Glucose Monitoring **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** DNS or Designee will audit 5 resident glucose checks for proper technique and device sanitation on random halls and shifts 5 times per week x4 weeks, then 3 times per week x4 weeks, then once per week x4 weeks, then once every other week x 4 weeks, then monthly x 2 months. Audit results will be discussed monthly in QAPI and adjustments will be made as needed to ensure on-going compliance.	

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	1d. Resident C's record was reviewed on 11/1/23 at 11:30 a.m. Diagnoses on Resident C's profile included diabetes mellitus due to underlying diabetic chronic kidney disease. A physician's order for Resident C, dated 4/19/23, indicated check blood sugar before meals and at bedtime. Humalog kwikpen (fast-acting insulin) subcutaneous, inject as per sliding scale: if 0 - 199 = 0; 200 - 250 = 3u; 251 - 300 = 4u; 301 - 350 = 5u; 351 - 400 = 6u; 401 - 450 = 7u, call physician if over 450. A physician's order for Resident C, dated 10/7/23, indicated Glargine solution, inject 30 units subcutaneous twice a day, hold for accucheck (glucose monitoring) less than 100 and notify Nurse Practitioner (NP). A physician's order for Resident C, dated 10/28/33, Empagliflozin 25 mg give 1 table by mouth daily for diabetes mellitus. 1e. Resident RR's record was reviewed on 11/1/23 at 11:45 a.m. Diagnoses on Resident RR's profile included type 2 diabetes mellitus. A physician's order for Resident RR, dated 6/15/23, check blood sugar/accucheck twice daily before meals and at bedtime for diabetes mellitus, and call provider if any blood sugar less than 70 or greater than 400. 1f. Resident SS's record was reviewed on 11/1/23 at 11:55 a.m. Diagnoses on Resident SS's profile included type 2 diabetes mellitus with hyperglycemia. A physician's order for Resident SS, dated 8/31/23, Lispro solution inject per sliding scale: if			

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	151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units. Check blood sugar before meals for diabetes mellitus, call physician if less than 70 or greater than 400. During an interview on 11/1/23 at 9:48 a.m., QMA 19 indicated, when performing blood glucose monitoring, staff were to change gloves before and after each resident. The resident's finger was to be cleaned with an alcohol prep, let the finger dry, puncture the finger of resident's choice with a lancet, apply blood to the glucose stick, wait for the monitor to read, then tell the resident his/her reading. Remove gloves and wash hands. QMA 19 indicated there were enough glucometers available on the hallway for each resident to have their own, but the monitors were not labeled. Glucometers were supposed to be cleaned with alcohol and then use Sani wipes between each resident that contained bleach. When questioned if she let the glucometer dry, indicated "yes but not sure for how long". There were no residents on the A hallway with a communicable disease diagnosis. 2. During a random observation of the B hallway on 11/1/23 at 11:58 a.m., RN 21 indicated she had 7 residents who had orders for blood glucose monitoring at lunch time. There were 2 residents on the front hallway to include Resident TT and another resident who was unavailable, then she would check the 5 residents on the back of the hallway. On 11/1/23 at 12:00 p.m., RN 21 was observed to perform a blood glucose monitoring for Resident TT. RN 21 took a small basket from the top of the front medication cart of B hallway containing a glucometer, alcohol wipes and lancets, entered			

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	Resident TT's room, and set the basket on the residents over the bed table. RN 21 donned (put on) gloves, wiped the resident's finger with alcohol, immediately poked his finger, and told the resident the reading when it became available. RN 21 was observed to remove her gloves and used alcohol based hand sanitizer (ABHS) to cleanse her hands as she left the resident room. RN 21 immediately picked up the basket containing the same glucometer and supplies and went down the hallway to do a blood glucose reading for another resident. As RN 21 started to enter Resident Z's room, QMA 19 informed her she had completed all the remaining blood sugar monitoring due at lunch to include Resident Z's. RN 21 was not observed to clean the glucometer she was carrying before or after use on Resident TT and laying it among clean supplies in the basket. Resident TT's record was reviewed on 11/1/23 at 1:00 p.m. Diagnoses on Resident TT's profiled included type 2 diabetes and HIV disease. A physician's order for Resident TT, dated 3/16/23, Semglee solution (long-acting insulin) inject 45 units subcutaneously one time every Thursday for diabetes mellitus. A physician's order for Resident TT, dated 10/18/23, Dulaglutide solution (stimulates the pancreas to release insulin when blood glucose was high) inject 45 units subcutaneously at bedtime. The resident record lacked a physician's order for blood glucose monitoring. The resident record contained documentation blood glucose monitoring was completed on 10/31/23 at 8:48 a.m., 12:48 p.m., 5:13 p.m., and			

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11:16 p.m., and on 11/1/23 at 9:00 a.m.

During an interview on 11/1/23 at 12:13 p.m., RN 21 indicated, she had 2 glucose monitoring machines available on B hallway, one for each medication cart, there were no resident's that had a glucometer individually assigned. RN 21 indicated, glucometers were supposed to be cleaned with alcohol swabs after each use. When questioned, indicated she was aware Resident TT was diagnosed HIV positive, and he did not have his own glucometer. It was not a problem as lancets and blood glucose sticks contaminated with blood were disposed of in a sharps container.

During an interview on 11/1/23 at 12:27 p.m., QMA 16 indicated glucometers and other nursing equipment were cleaned with an alcohol pad before and after use. Indicated there was a tub of Sani wipes (label indicated for use in killing HIV) in the cart for use in cleaning off the top of the medication cart. Indicated she had performed blood sugar testing on Resident TT, indicated she thought he had his own glucometer.

During an interview on 11/1/23 at 12:47 p.m., DNS indicated there was one resident in the facility with a known communicable disease, Resident TT. Although there were many glucometers available in the hallways, the glucometers were not assigned to individual residents.

The process of testing resident glucose levels included, gathering supplies and a glucometer from the medication cart, sanitize hands, don gloves, wipe the resident site to be tested with an alcohol wipe and allow to dry without fanning or blowing, put a strip in the glucometer, prick a finger with a lancet, put blood on the strip and put it into the glucose machine, wait for reading, wipe

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site to assure not continuing to bleed, and bandage if needed. To cleanse the glucometer, it was to be wiped off with Sani wipes and wait for contact time, she was not sure of time. Remove gloves and sanitize hands with ABHS in room. Soiled lancet and glucose stick were to be disposed of in sharps box. Resident TT diagnosed with HIV did not have his own glucometer.

On 11/1/23 at 1:45 p.m., the Vice President of Clinical Services (VPCS) indicated, the facility did not have a specific policy for cleaning of glucometers, they used the Centers for Disease Control (CDC) guidelines.

An American Society of Clinical Pathology Summary of Glucometer Cleaning Guidelines - February 2010, indicated, "Be sure you are familiar with which glucometer manufacturer[s] your facility[ies] use[s] and the cleaning procedures recommended by that manufacturers[s] ...If the manufacturer does not provide specific cleaning recommendations or as a conservative approach to infection control for glucometers with minimal cleaning requirements, facilities may want to consider cleaning glucometers with high -level disinfectants ...Be familiar with the amount of time the disinfectant solution is supposed to contact the equipment or how long active cleaning should be performed to ensure complete disinfection ... CDC recommends a 1:100 dilution of household bleach for cleaning blood-contaminated environmental surfaces that have been previously cleansed of visible material ...""

On 11/1/23 at 2:01 p.m., the DNS provided a Competency for Blood Glucose Monitoring checklist, and indicated the list was currently used during the skills fair yearly. The list indicated, "1.

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	Cleanse the machine with designated disinfecting wipe and allow for kill time ...2. Knock on door ...bring in supplies. 3. Wash hands and apply gloves. 4. Allow resident to wash his/her hands with soap and water if able, if unable, wipe finger with alcohol swab and allow to air dry ...7. Use a new lancet and apply it to the side of the chosen finger and let it puncture the skin. 8. Let it form a small round blood drop and apply it to the top of the test strip ...11. Remove the used test strip by hand or by pushing the ejector button ...12. Wash hands. 13. Clean the machine with designated disinfecting wipe and allow for kill time ..." This citation relates to Complaint IN00419669. 3.1-18(b)(1)			