

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/23/2012
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NAME OF PROVIDER OR SUPPLIER SHIELDS HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 2288 NICHOLAS CT SEYMOUR, IN 47274
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R0000	<p>This visit was for a Post Survey Revisit (PSR) to the State Licensure Survey completed on 5-31-2012.</p> <p>Survey dates: August 22 and 23, 2012</p> <p>Facility number: 004376 Provider number: 004376 AIM number: N/A</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: Residential: 33 Total: 33</p> <p>Census payor type: Other: 33 Total: 33</p> <p>Sample: 4</p> <p>These State Residential findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review 8/29/12 by Suzanne Williams, RN</p>	R0000	<p>Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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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R0121	<p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p>			

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		R0121	<p>Citation #1 R 121 410 IAC 16.2-5-1.4(f) (1-4) Personnel- Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? No residents were found to be affected.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents were found to be affected.</p> <p>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? The Residence Director and Wellness Director were re-educated to our policy and procedure regarding Mantoux skin testing for employees. The Wellness Director and/or designee will be responsible to ensure staff have Mantoux skin testing completed per our policy and procedure to ensure compliance with Indiana state ruling R 121 410 IAC 16.2-5-1.4(f)</p>		10/10/2012		

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	<p>Based on record review and interview, the facility failed to ensure 2 employees received timely tuberculin skin testing prior to beginning employment in a sample of 5 staff reviewed for timely tuberculin skin testing. (LPN #1, LPN #2)</p> <p>Findings include:</p> <p>LPN #1's employee file was reviewed on 8-23-12 at 9:25 a.m. Her start date of</p>		<p>(1-4) Personnel.</p> <p>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The Wellness Director and/or designee will perform random weekly audits of staff Mantoux records to ensure continued compliance for a period of 6 months. Findings will be reviewed through the Shields House QA process after 6 six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan.</p> <p>By what date will the systemic changes be completed?</p> <p>October 10, 2012</p>		

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	<p>employment was indicated as 7-9-12. Review of her tuberculin skin testing indicated she received the first step testing on 7-19-12 and the second step testing on 8-2-12.</p> <p>LPN #2's employee file was reviewed on 8-23-12 at 9:25 a.m. Her start date of employment was indicated as 6-28-12. Review of her tuberculin skin testing indicated she received a first step testing on 6-26-12. Documentation of a second tuberculin skin testing was not indicated to have occurred within 1-3 weeks after the first. Another first step tuberculin skin test was administered on 8-2-12, followed by a second step testing on 8-14-12.</p> <p>In interview with Corporate Nurse #2 on 8-23-12 at 12:03 p.m., she indicated it appeared that LPN #2 had begun her tuberculin skin testing, but failed to obtain the second step. She indicated the tuberculin skin testing was started over in August 2012.</p> <p>This state residential rule was cited on 5-31-12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>						

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R0214	<p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on interview and record review, the facility failed to ensure an updated and complete assessment was conducted after an initial elopement of a resident from the facility for 1 of 1 resident reviewed for elopement in a sample of 4. (Resident #4)</p> <p>Findings include:</p> <p>The Resident Director provided a copy of a reportable incident on 8-22-12 at 1:52 p.m. that had been sent to the Indiana State Department of Health (ISDH) which indicated Resident #4 had eloped from the building on 7-7-12 at 5:00 p.m.</p> <p>Review of a document entitled, "Universal Incident/Occurrence Report" indicated Resident #4 "eloped from facility by means of the northwest exit door. [Name of Wellness Director] and a visitor assisted the resident back inside the facility. Resident was walking on the sidewalk. Resident appears unharmed after full assessment completion by</p>	R0214	<p>Citation #2 R 214 410 IAC 16.2-5-2(a) Evaluation- Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? An updated elopement assessment has been completed and placed in Resident #4's chart. Resident #4 has been identified as an elopement risk.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents were found to be affected.</p> <p>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</p>	10/10/2012			

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	<p>myself." This report was signed by LPN #3 on 7-7-12 Attached to this report was documentation by the Wellness Director, dated 7-7-12, which indicated LPN #3 and CNA #2 had received information to their pagers which indicated the northwest door had been opened. It indicated LPN #3 did not have her pager on her and it did not indicate if CNA #1 had her pager on her. It indicated both employees were later inserviced to get their pagers when they came on shift and to respond to alarms.</p> <p>In a written statement, dated 7-9-12, by LPN #3, she indicated all staff were in the dining area assisting with the supper meal at the time of the elopement. She indicated Resident #4 got up from the dining table and walked toward the restroom. She indicated the door alarms did alert on the staff's pagers. She did not indicate if the staff had the pagers on their person or if anyone responded to the alarms. She indicated the receptionist brought the resident back into the building.</p> <p>In an undated written statement by the receptionist, she indicated a family member of another resident came to her on 7-7-12 to inform her that Resident #4 was outside of the front of the building. She indicated she went outside and</p>		<p>The Residence Director and Wellness Director were re-educated to our policy and procedure regarding assessment completion and elopement. The Wellness Director and/or designee will be responsible for ensuring Elopement Risk Assessments will be completed per our policy and procedure to ensure compliance with R214 410 IAC 16.2-5-2(a) Evaluation.</p> <p>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Wellness Director and/or designee will perform random weekly audits of resident assessments to ensure continued compliance for 6 months. Findings will be reviewed through our Shields House QA process after 6 months in order to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan.</p> <p>By what date will the systemic changes be completed? October 10, 2012</p>				

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	<p>assisted the resident back into the building. She indicated the resident told her that she was going to church.</p> <p>Review of the clinical record of Resident #4 on 8-22-12 at 9:47 a.m., indicated an updated "Elopement Risk Assessment" had not been conducted on or around 7-7-12. A previous one conducted on 5-15-12 indicated she was not an elopement risk. The assessment indicated, "Staff redirects res[ident] as necessary. Res [Resident] is not exit seeking at this x [time.]" The next "Elopement Risk Assessment" located in the clinical record was dated 8-9-12, after a second time in which the resident eloped from the building on 8-9-12 at 6:15 p.m.</p> <p>In review of two documents entitled, "Disciplinary Action Report," dated 7-10-12, it indicated LPN #3 and CNA #1 were given "Final [Written] Notice" for "willful failure to perform duties." It indicated staff are expected to obtain their pager at the beginning of each shift and to keep it with them throughout their shift and to respond to call lights and alarms that are sent to the pager.</p> <p>Review of the service plan dated 7-7-12 indicated, "Resident exited the facility unassisted. Goal: Resident will have</p>			

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	<p>[sign for no or none] further elopement episodes thru next review. Intervention: U/A C&S [urinalysis with culture and sensitivity] and staff education. MD notification/family notification." The service plan did not indicate any plans to conduct an elopement assessment to help identify causative factors related to the elopement or an increased risk of further elopements.</p> <p>In interview with Corporate Nurse #2 on 8-23-12 at 12:03 p.m., she indicated, "From reviewing the elopement policy, it looks like an elopement assessment [for elopement risk] should have been done after the elopement on 7-7-12."</p> <p>Review of a policy entitled, "Elopement or Missing Resident," was provided by Corporate Nurse #1 on 8-22-12 at 1:22 p.m. This document indicated, "Elopement assessments will be completed as part of the follow-up for any resident who elopes. Evaluation of risk should include analysis of why resident eloped. Elopement Assessment must be completed within 24 hours of the incident...Resident Service Plan will be reviewed with the regional team members to ensure appropriate interventions are in place to safeguard the resident."</p> <p>This state residential rule was cited on</p>						

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	5-31-12. The facility failed to implement a systemic plan of correction to prevent recurrence.			

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R0217	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review, the facility failed to ensure an appropriate service plan was developed regarding the services needed for a resident after an initial elopement of a resident from the facility for 1 of 1 resident reviewed for elopement in a sample of 4. (Resident #4)</p>	R0217	<p>Citation #3 R 217 410 IAC 16.2-5-2(e) (1-5) Evaluation- Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? No residents were found to be</p>	10/10/2012			

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	<p>Findings include:</p> <p>The Resident Director provided a copy of a reportable incident on 8-22-12 at 1:52 p.m. that had been sent to the Indiana State Department of Health (ISDH) which indicated Resident #4 had eloped from the building on 7-7-12 at 5:00 p.m.</p> <p>Review of a document entitled, "Universal Incident/Occurrence Report" indicated Resident #4 "eloped from facility by means of the northwest exit door. [Name of Wellness Director] and a visitor assisted the resident back inside the facility. Resident was walking on the sidewalk. Resident appears unharmed after full assessment completion by myself." This report was signed by LPN #3 on 7-7-12 Attached to this report was documentation by the Wellness Director, dated 7-7-12, which indicated LPN #3 and CNA #2 had received information to their pagers which indicated the northwest door had been opened. It indicated LPN #3 did not have her pager on her and it did not indicate if CNA #1 had her pager on her. It indicated both employees were later inserviced to get their pagers when they came on shift and to respond to alarms.</p> <p>In a written statement, dated 7-9-12, by</p>		<p>affected. Resident #4 had an updated elopement risk assessment completed. The resident's service plan was reviewed and updated to include interventions to minimize the risk for elopement.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents were found to be affected.</p> <p>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? The Residence Director and Wellness Director were re-educated to our policy and procedure regarding service level assessment completion. The Residence Director and/or designee will be responsible for ensuring that service assessments are accurate and updated per our policy to ensure continued compliance with R217 410 IAC 16.2-5-2(e)(1-5) Evaluation.</p> <p>How will the corrective action(s) will be monitored to</p>				

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	<p>LPN #3, she indicated all staff were in the dining area assisting with the supper meal at the time of the elopement. She indicated Resident #4 got up from the dining table and walked toward the restroom. She indicated the door alarms did alert on the staff's pagers. She did not indicate if the staff had the pagers on their person or if anyone responded to the alarms. She indicated the receptionist brought the resident back into the building.</p> <p>In an undated written statement by the receptionist, she indicated a family member of another resident came to her on 7-7-12 to inform her that Resident #4 was outside of the front of the building. She indicated she went outside and assisted the resident back into the building. She indicated the resident told her that she was going to church.</p> <p>In review of two documents entitled, "Disciplinary Action Report," dated 7-10-12, it indicated LPN #3 and CNA #1 were given "Final [Written] Notice" for "willful failure to perform duties." It indicated staff are expected to obtain their pager at the beginning of each shift and to keep it with them throughout their shift and to respond to call lights and alarms that are sent to the pager.</p>		<p>ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Residence Director and/or designee will perform random weekly audits of resident service plans to ensure accuracy of the assessment to ensure continued compliance for a period of 6 months. Findings will be reviewed through the Shields House QA process after 6 six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan.</p> <p>By what date will the systemic changes be completed? October 10, 2012</p>				

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	<p>Review of the clinical record of Resident #4 on 8-22-12 at 9:47 a.m., indicated an updated "Elopement Risk Assessment" had not been conducted on or around 7-7-12. A previous one conducted on 5-15-12 indicated she was not an elopement risk. The assessment indicated, "Staff redirects res[ident] as necessary. Res[ident] is not exit seeking at this x [time.]" The next "Elopement Risk Assessment" located in the clinical record was dated 8-9-12, after a second time in which the resident eloped from the building on 8-9-12 at 6:15 p.m.</p> <p>Review of the service plan dated 7-7-12 indicated, "Resident exited the facility unassisted. Goal: Resident will have [sign for no or none] further elopement episodes thru next review. Intervention: U/A C&S [urinalysis with culture and sensitivity] and staff education. MD notification/family notification." The service plan did not indicate any plans to conduct an elopement assessment to help identify causative factors related to the elopement or an increased risk of further elopements.</p> <p>In interview with Corporate Nurse #2 on 8-23-12 at 12:03 p.m., she indicated, "From reviewing the elopement policy, it looks like an elopement assessment [for elopement risk] should have been done</p>			

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	<p>after the elopement on 7-7-12."</p> <p>Review of a policy entitled, "Elopement or Missing Resident," was provided by Corporate Nurse #1 on 8-22-12 at 1:22 p.m. This document indicated, "Elopement assessments will be completed as part of the follow-up for any resident who elopes. Evaluation of risk should include analysis of why resident eloped. Elopement Assessment must be completed within 24 hours of the incident...Resident Service Plan will be reviewed with the regional team members to ensure appropriate interventions are in place to safeguard the resident."</p> <p>This state residential rule was cited on 5-31-12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>						

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R0356	<p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following:</p> <ol style="list-style-type: none"> (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. 	R0356	<p>Citation #4 R 356 410 IAC 16.2-5-8.1(i) (1-8) Clinical Records- Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? No residents were found to be affected. Resident #17's emergency file was updated with hospital preference.</p> <p>How the facility will identify other residents having the potential to be affected by the</p>	10/10/2012			

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			<p>same deficient practice and what corrective action will be taken? No other residents were found to be affected. A review was conducted of other resident's emergency files. Emergency information was updated as necessary to ensure compliance with R356 410 IAC 16.2-5-8.1(i) (1-8).</p> <p>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? The Residence Director and Wellness Director were re-educated to the Indiana state ruling R356 410 IAC 16.2-5-8.1(i) (1-8) Clinical Records. The Residence Director and/or designee will be responsible to ensure the emergency file is maintained in compliance through random reviews.</p> <p>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Residence Director and/or designee will perform random weekly audits of the emergency file information to ensure</p>		

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	<p>Based on interview and record review, the facility failed to ensure the resident's preference for a hospital was indicated on the current emergency file information for 1 of 4 residents reviewed for emergency file information. (Resident #17)</p> <p>Findings include:</p> <p>Resident #17's clinical record was reviewed on 8-23-12 at 11:25 a.m. Review of the emergency file information indicated no information was present for his preference of a hospital. In review of 3 of 4 records for emergency file information, the documentation for hospital preference was located on the back side of the page containing other emergency file information. In Resident #17's clinical record, the back side of the same page was entirely blank.</p>		<p>continued compliance for a period of 6 months. Findings will be reviewed through the Shields House QA process after 6 six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan.</p> <p>By what date will the systemic changes be completed? October 10, 2012</p>				

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	<p>In interview with the Resident Director on 8-23-12 at 11:58 a.m., she indicated she had been having staff update the emergency files of the residents. She indicated Resident #17's emergency file may have not been reviewed yet or had been missed.</p> <p>This state residential rule was cited on 5-31-12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>						

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R0406	<p>410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection.</p> <p>Based on observation, interview and record review, the facility failed to ensure appropriate infection control policies and practices in regard to cleaning and disinfecting of a resident's glucometer for 1 of 1 resident's glucometer which is used by staff to obtain glucose readings. (Resident #15)</p> <p>Findings include:</p> <p>During 1 of 2 medication pass observations with LPN #3 on 8-22-12 at 11:23 a.m., the nurse was observed to obtain a blood glucose test from Resident #15. She indicated Resident #15 is the only current resident who requires the assistance of staff to obtain his blood sugar tests. She indicated the glucometer belonged to the resident and that he is the only person for whom it is used. She indicated the cleaning and sanitation of the machine is conducted according to the manufacturer's instructions after each use. She indicated the instructions suggest to use a lint free cloth and a mild detergent. She indicated an alcohol wipe is also used</p>	R0406	<p>Citation #5 R 406 410 IAC 16.2-5-12(a) Infection Control- Offense What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? No residents were found to be affected. Staff was reeducated to proper disinfecting of the glucometer.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents were found to be affected.</p> <p>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? The Wellness Director provided</p>	10/10/2012			

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	<p>in cleaning the glucometer. After LPN #3 obtained the blood sugar test, she was observed to first cleanse the glucometer with an alcohol wipe. She then moistened a paper towel with tap water from the kitchen sink and liquid soap in a dispenser at the kitchen sink. She then rinsed the glucometer with a paper towel moistened only with water, then dried the glucometer with a dry paper towel.</p> <p>A copy of the glucometer's manufacturer's recommendations for cleaning of the glucometer was provided on 8-22-12 at 1:22 p.m. by Corporate Nurse #1. On page 40 of the recommendations, it indicated, "Cleaning the Meter. If the meter gets dirty, use a moist (NOT WET) lint-free cloth dampened with a mild detergent. No not get water inside the meter or hold it under running water. Do not use glass or household cleaners on the meter. Do not try to clean the test strip holder." No information was identified on disinfection or sanitization of the glucometer in the manufacturer's recommendations.</p> <p>In interview with Corporate Nurse #1 on 8-22-12 at 1:25 p.m., he indicated there was not a policy in place in regard to cleaning or sanitizing of glucometers. He indicated he thought staff should use standard precautions, such as</p>		<p>re-education to licensed staff concerning infection control practices to be utilized when disinfecting the glucometer. The Wellness Director and/or designee will perform random reviews to ensure compliance with Indiana state ruling R406 410 IAC 16.2-5-12(a).</p> <p>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Wellness Director and/or designee will perform random weekly audits of glucometer use to ensure continued compliance for a period of 6 months. Findings will be reviewed through the Shields House QA process after 6 six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan.</p> <p>By what date will the systemic changes be completed? October 10, 2012</p>				

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	<p>handwashing and glove use or using an alcohol pad to clean the glucometer. In interview on 8-22-12 at 4:28 p.m., Corporate Nurse #1 indicated he was attempting to get information from the Centers of Disease Control in regard to glucometer cleaning and staff usage.</p> <p>In interview with Corporate Nurse #2 on 8-23-12 at 1:58 p.m., she indicated, "We have bleach wipes to clean the glucometers with now." She indicated the corporation will be evaluating this issue more in regard to staff that must assist residents with obtaining blood sugar testing.</p> <p>This state residential rule was cited on 5-31-12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>						