

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/25/2014
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NAME OF PROVIDER OR SUPPLIER  WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
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F000000	<p>This visit was for a recertification and state licensure survey. This visit resulted in an Extended Survey-Immediate Jeopardy.</p> <p>Survey dates: September 16-19, 2014 Extended survey dates: September 22-25, 2014.</p> <p>Facility number: 000109 Provider number: 155202 AIM: 100266290</p> <p>Survey team: Laura Brashear, RN, TC Vicki Nearhoof, RN Mary Weyls, RN, September 16-19, 2014 Geoff Harris, RN, September 16-19, 22, 23, 2014 Brooke Harrison, RN, September 16-19, 22, 23, 2014</p> <p>Census bed type: SNF/NF: 79 Total: 79</p> <p>Census payor type: Medicare: 8 Medicaid: 49 Other: 22 Total: 79</p>	F000000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance of September 29, 2014.</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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F000241 SS=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1</p> <p>Quality review completed 10/1/14 by Brenda Marshall, RN.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident was transferred to and from a shower room for 1 of 1 random observation in a manner that promoted personal dignity. (Resident #15)</p> <p>Finding includes:</p> <p>On 9/22/14 at 12:35 p.m. a Hospice Aide #19 was observed to transfer Resident #15 in the hallway to a shower room. The resident was sitting on a shower chair wearing a hospital gown, with back exposed, a folded sheet over his lap with exposed lower extremities, and to have a urinary catheter drainage bag, not covered in a dignity bag, hanging on the side of the chair.</p>	F000241	<p>It is the intent of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 1. Action Taken: A. Inservice Hospice Aid #19 1:1 on Dignity, Privacy and covers for foley catheter bags. B. Reported deficiency to Hospice Company Supervisor. C. Hospice Company inservice their staff on 9\24\14 on Dignity and Foley Catheter Bags and Hospice Aid # 19 was in attendance. D. Hospice Company re-inservice and educated their staff on Hospice in LTC: Patients Rights, Dignity and Model of Care on 9\29\14 and Hospice Aid #19 was in attendance. E. All Facility Staff inservice on Dignity and F\C bags on 10\8\14 and a collaborative Hospice staff inservice at the</p>	10/07/2014

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	<p>On 9/22/14 at 12:40 p.m., the resident was observed to be transferred again down the hallway on a shower chair wearing a hospital gown, with back exposed, a folded sheet over his lap with exposed lower extremities, and to have a urinary catheter bag, not covered in a dignity bag, hanging on the side of the chair. The Hospice Aide was interviewed and indicated she knew the catheter bag should have been covered and indicated she had folded a sheet over his lap.</p> <p>Resident #15's Minimum Data Set assessment was reviewed on 9/25/14 at 3:00 p.m. The assessment, dated 6/7/14, indicated the resident required extensive to total assistance with all activities of daily living and was non-ambulatory.</p> <p>The Administrator was interviewed on 9/24/14 at 2:00 p.m. The Administrator indicated she believed there were collaborative in service training with the Hospice staff. She indicated she would attempt to get the information from the Hospice company. On 9/25/14 at 3:00 p.m. the Administrator produced forms titled "... (name of company) Hospice Care Certified Home Health Aide and Personal Care Assistant Skills Check List." The form for Hospice Aide #19, dated, 9/4/13, indicated "met" for the</p>		<p>facility on 10\9\14 for Dignity, Patients Rights, and foley catheter bags. F. Resident #15, along with all other residents with foley catheters, have been changed to bags with built in covers. 2. Others Identified: A. 100% audit of residents with no other findings. B. Resident #15, along with all other residents with foley catheter's have been changed to a bag with a built in covers. 3. Systems in Place A. Will inservice and educate any new staff members from present Hospice Company and staff from any new Hospice Company on Dignity before they perform care in the building. B. New facility staff are educated in orientation on Residents Rights &amp; Dignity prior to performing care. C. All new residents admitted to facility with a foley catheter will have bag with built in cover. 4. Monitoring A. DON\Designee will monitor foley catheter bags for dignity 3 times a week for 12 weeks, 2 times a week for 8 weeks and 1 time a week for 4 weeks. B. DON\Designee will monitor any new resident admitted to facility with a foley catheter to assure correct bag with built in cover is in place. This will be ongoing. C. DON\Designee will monitor dependent residents' ADL care to assure Dignity and Privacy is not violated 3 times a week for 12 weeks, 2 times a week for 8 weeks and 1 time a week for 4 weeks. D. IDT will observe foley</p>	

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F000364 SS=E	<p>demonstration of skills. The Administrator indicated she was not able to obtain information of training Hospice staff on facility policies and procedures.</p> <p>On 9/25/14 at 1:37 p.m., the Director of Nursing provided a current document titled "Resident's Rights," dated 7/1/11, which included but was not limited to, "Visits-Privacy-Confidentiality ...Privacy in your room and during bathing, medical treatment, and personal care." The DON indicated the resident and urinary drainage bag should have been covered.</p> <p>A facility policy identified as current provided by the DON on 9/25/14, was titled "Indwelling Catheter Justification/Decision Diagram," dated 6/1/12, included, but was not limited to, "Complete Care Plan for Indwelling ...Provide a catheter bag cover to promote dignity...." The DON indicated this was included in the facility's training and expectations of staff.</p> <p>3.1-3(p)(4)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable,</p>		<p>catheter dignity during their weekly rounds. E. Administrator\Designee will review all audits\proficiency's as completed in daily QA stand up meeting. Any issues will be immediately addressed and corrected. F. Results\Issues identified will be discussed with IDT at monthly QA meeting and with the Medical Director at the Quarterly QA meeting and/or as needed for determination for ongoing monitoring and/or changes to the QA meeting. Date of Compliance: 10\7\2014</p>	

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	<p>attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to provide meals the residents found to be palatable for 2 of 3 observations of noon meal service in that the vegetables were observed to be watery and over cooked. Finding includes:</p> <p>During a stage 1 interview on 9/17/2014 at 2:44 p.m., Resident #19 indicated the vegetables were "mushy" and in water with no flavor.</p> <p>During an observation on 9/17/14 at 9:50 a.m., Dietary Aide #18 pureed vegetables. A large pan of cooked vegetables (broccoli, cauliflower and carrots) was in water in the oven to keep warm. The DM indicated the large pan of vegetables was for the noon meal service.</p> <p>On 9/22/14 at 11:50 a.m., a test tray of the lunch meal was obtained. The meal included California blend vegetables (cauliflower, broccoli and carrots) were soft, lacked taste, and were watery.</p> <p>The Food Council Minutes from 8/21/14, provided by the DM (Dietary Manager) on 9/22/14 at 12:45 p.m., included but was not limited to, the cauliflower/broccoli were too done.</p>	F000364	<p>It is the intent of this facility to ensure that each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. 1. Action Taken: A. Dietary Manager implemented batch cooking of vegetables to reduce the amount of time that vegetables were being held before serving on 9\26\14. 2. Potential to be affected: A. Depending on resident preference all other residents have the potential to be affected. 3. Systems in Place: A. Inservice\educated all Dietary Staff on Batch Cooking, Palatable food, and vegetables on 10\8\14. 4. Monitoring: A. Dietary Manager\Designee will complete Quality of Food Audit on one resident in Dining Room and one resident with a hall tray 3 times a week for 12 weeks, 2 times a week for 8 weeks and 1 time a week for 4 weeks. Any issues identified in the audits will be immediately addressed. B. Dietary Manager\Designee will hold Food Council with residents 1 time a week for 8 weeks and then bi-weekly for 8 weeks and monthly thereafter. Any issues identified in the meeting will be immediately addressed. C. Administrator\Designee will review all audits completed in daily QA stand up meeting. Any</p>	10/07/2014

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F000371 SS=E	<p>On 9/25/14 at 3:25 p.m., the DM was interviewed and indicated the vegetables should not have been cooked that early for noon meal service. The DM indicated years ago they had a steamer and the vegetables were much better. The vegetables have to be cooked in water since we cannot steam them any longer.</p> <p>3.1-21(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review the facility failed to store dishware to prevent contamination for 4 of 4 kitchen observations. Finding includes: On 9/16/14, during the initial kitchen tour that began at 9:30 a.m., with the DM (Dietary Manager), the manager indicated there was one hand washing sink in the kitchen. During observations on: 9/16/14 at 10:25 a.m., 9/17/14 at 9:50 a.m., 9/18/14 at</p>	F000371	<p>issues will be immediately addressed and corrected. D. Results\issues identified will be discussed with IDT at monthly QA meeting and with the Medical Director at the Quarterly QA meeting and\or as needed for determination for ongoing monitoring and\or changes to the QA meeting. Date of Compliance: 10\7\14</p> <p>It is the intent of this facility to store, prepare, distribute and serve food under sanitary conditions. A. Action Taken: 1. Drinking glasses on carts were removed from under the soap dispenser beside the handwashing sink and placed in an appropriate clean and dry location. B. Potential to be affected: 1. All residents had the potential to be affected. C. Systems in Place: 1. All Dietary Staff was inserviced\educated on storing utensils, tableware, and equipment. D. Monitoring: 1. Dietary Manager\Designee will complete audit form to ensure that glasses on carts are stored in</p>	10/07/2014

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F000441 SS=K	<p>10:50 a.m., and 9/22/14 10:30 a.m., clean glasses were stored under the soap dispenser utilized for the hand washing sink.</p> <p>The DM provided on 9/25/14 at 1:05 p.m. a current facility policy titled "Storing Utensils, Tableware, and Equipment," dated 2011. The policy included but was not limited to: "Procedure: 1. Clean and sanitize utensils and equipment will be stored in a clean, dry location in a way that keeps them from contamination by splash ...."</p> <p>During an interview on 9/25/14 at 3:25 p.m., the DM indicated the drinking glasses were stored in racks on wheels. The manager indicated the kitchen staff should not have placed the racks so close to the sink.</p> <p>3.1-21(i)(3)</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p>				<p>a clean and dry location 5 times a week for 4 weeks, 3 times a week for 8 weeks, and 1 time a week for 12 weeks. 2. Administrator completes a weekly kitchen sanitation audit form which includes glassware storage and this will be ongoing. 2. Administrator\Designee will review all audits as completed in daily QA stand up meeting. Any issues will be immediately addressed and corrected. 3. Results\issues identified will be discussed with IDT at monthly QA meeting and with the Medical Director at the quarterly QA meeting and\or as needed for determination for ongoing monitoring and\or changes to the QA meeting. Date of Compliance: 10\7\14</p>		

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	<p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review the facility failed to ensure proper sanitation procedures for cleaning 14 of 14 contaminated, reusable blood glucose meters resulting in potential, serious harm from exposure to a communicable disease for 21 of 21 residents reviewed for blood glucose monitoring (Residents #1, #7, #14, #16, #18, #19, #26, #27, #30, #32, #38, #51,</p>	F000441	It is the intent of this facility to establish and maintain an infection control program that is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. 1. Action Taken: a. Improper sanitizer wipes have been removed from facility. b. All glucometers that are in use were immediately disinfected with 1:10 bleach solution. c. Any resident with a known communicable	09/25/2014

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	<p>#61, #62, #65, #73, #74, #90, #91, #121, and #122).</p> <p>The immediate jeopardy began on 9/22/14 and was identified on 9/22/14 at 3:00 p.m. The Administrator and Director of Nursing were notified of the immediate jeopardy at 12:15 p.m. on 9/23/14. The immediate jeopardy was removed on 9/25/14, but noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include: On 9/22/14 at 11:40 a.m. Resident #19's blood sugar was tested. LPN #1 cleaned the blood glucose monitor with a sterile alcohol prep pad, waved the monitor in the air to dry, then proceeded to perform the blood glucose test on Resident #19. The LPN indicated she was drying the monitor. LPN #1 indicated there were two glucose monitors in use on the medication cart. She indicated she used alcohol swabs to cleanse the blood glucose monitors.</p> <p>On 9/22/14 at 2:20 p.m., LPN #2 was interviewed regarding sanitization of glucometers. LPN #2 took a canister of</p>		<p>disease will have glucometer designated for their use only. d. Germicidal disposable sanitizer wipes for glucometer cleaning are in use for glucometer disinfection (EPA registered disinfectant). e. Implementation of new Policy and Procedure for Cleaning/Disinfecting/Maintaining Glucose Meters. f. LPN\RN, &amp; QMA employees have been inserviced on new policy and procedure of glucometer cleaning with return demonstration prior to working an additional shift. g. Improper sanitizer wipes have been removed from formulary so that incorrect order cannot be placed and received. Only the germicidal disposable sanitizer wipes for glucometer cleaning (EPA approved) will be available on formulary or order and receive. h. 1:1 education given to medical supply clerk for appropriate ordering and stocking. 2. Others Identified: a. Any resident that received a glucometer check would have had potential to be affected. 3. Systems in Place: a. Implementation of new Policy and Procedure for Cleaning/Disinfecting/Maintaining Glucose Meters. b. LPN\RN &amp; QMA employees inserviced and educated on new Policy and Procedure for Cleaning/Disinfecting/Maintaining Glucose Meters with germicidal disinfectant wipes. c. Any resident with a known</p>				

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	<p>sanitizing wipes from the medication cart drawer and indicated she would clean the meter with a sanitizing wipe, keeping the surface wet for one minute, then let it air dry. The LPN indicated she worked on all facility units.</p> <p>On 9/22/14 at 2:30 p.m., RN #3 indicated she would sanitize glucometers with an alcohol prep wipe. The nurse indicated there were no residents currently on the Moonlight Bay Unit that required blood glucose monitoring. Four blood glucose monitors were observed in a drawer in the medication cart.</p> <p>On 9/22/14 at 3:00 p.m., the product "Sani-Wipe" label was read. The canister labeled, "PROFESSIONAL SANI-WIPE NO RINSE HARD SURFACE, NON-POROUS SURFACE SANITIZING WIPE," indicated, "...Designed for sanitizing cleaned hard, non-porous food contact surfaces. ..."</p> <p>The product label indicated the sanitizer was 99.999% effective in 60 seconds against Staphylococcus aureus, Escheria coli, and Shigella boydii on hard, non-porous food contact surfaces. The label indicated, "...For use in retail and institutional food establishments, food</p>		<p>communicable disease will have glucometer designated for their use only. d. All new hire LPN\RN &amp; QMA employees will be educated, trained on glucometer cleaning and disinfection with return demonstration prior to assignment given along with new Policy and Procedure for Cleaning/Disinfecting/Maintaining Glucose Meters. 4. Monitoring:</p> <p>a. DON\Designee will audit\monitor glucometer cleaning and disinfection 5 days per week for 4 weeks on each shift. DON\Designee will audit\monitor glucometer cleaning and disinfection 3 days per week times 4 weeks on each shift. DON\Designee will audit\monitor glucometer cleaning and disinfection 1 day per week times 4 weeks on each shift. DON\Designee will then audit\monitor glucometer cleaning and disinfection twice a month on each shift for 10 months. b. Administrator\Designee will review all audits\proficiency's as completed in the daily QA stand up meeting. Any issues will be immediately addressed and corrected. c. Results of audits\proficiency's will be taken to the QA committee meeting for ongoing monitoring. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 9\25\14. IDR: This facility is requesting an IDR in relation to scope and</p>		

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	<p>processing plants and other health department regulated food facilities ...."</p> <p>The information on the canister did not indicate the product was an effective disinfectant for blood borne pathogens and did not indicate it contained bleach. On 9/22/14 at 3:00 p.m., an owner's booklet for the blood glucose monitoring system used in the facility was provided by the DON. The booklet indicated the meter should be cleaned between use with soap and water. The booklet indicated the meter was intended for use by health care professionals in a clinical setting, but did not indicate how the meter should have been cleaned between uses when used for multiple residents. On 9/22/14 at 4:00 p.m., the Director of Nursing (DON) was interviewed. The DON indicated the Corporate Quality Assurance Nurse indicated in a phone conversation the white canister with the red top (Sani-Wipe) that was used to clean the blood glucometers was not the correct product for glucometer sanitation. She indicated the correct product came in a white canister with a purple lid or was bleach wipes. The DON indicated LPN #1, who was observed using the incorrect</p>		severity given for F tag 441 K.	

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	<p>sanitation procedure, worked on all units in the facility.</p> <p>On 9/23/14 at 11:00 a.m., the Administrator indicated the wrong "Sani-Wipe" product was ordered. She indicated the item number for the incorrect wipe was item #16605 and the product was ordered on 7/15/14. The administrator provided the product order documentation, dated 7/15/14 and indicated item #16602 was the product approved for blood glucose monitor sanitation that should have been ordered.</p> <p>On 9/23/14 at 11:06 a.m., the DON indicated extra supplies were kept in boxes on the floor of the supply room until the product was needed to restock the shelves. She indicated the shelf used to store the sanitizing wipes was bare last week and indicated the Sani-Wipes were placed on the shelf for use last week.</p> <p>The DON indicated the product was not used prior to stocking the shelf last week and she was not able to determine when the product was used prior to the observation of use on 9/22/14.</p> <p>Resident #91's record was reviewed on 9/22/14 at 4:30 p.m. Diagnoses included, but were not limited to diabetes</p>			

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	<p>and a communicable blood borne pathogen disease. A physician's recapitulation order, dated 9/1/14-9/30/14, indicated Resident #91 had blood glucose monitoring 3 times a day.</p> <p>Resident #1's record was reviewed on 9/22/14 at 4:35 p.m. Diagnosis included, but was not limited to diabetes. A physician's recapitulation order, dated 9/1/14-9/30/14, indicated Resident #1 had blood glucose monitoring 4 times a day.</p> <p>Resident #7's record was reviewed on 9/22/14 at 4:35 p.m. Diagnosis included, but was not limited to diabetes. A physician's recapitulation order, dated 9/1/14-9/30/14, indicated Resident #7 had blood glucose monitoring 2 times a day.</p> <p>Resident #14's record was reviewed on 9/22/14 at 4:40 p.m. Diagnosis included, but was not limited to diabetes. A physician's recapitulation order, dated 9/1/14-9/30/14, indicated Resident #14 had blood glucose monitoring 3 times a day.</p> <p>Resident #16's record was reviewed on 9/22/14 at 4:40 p.m. Diagnosis</p>			

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	<p>included, but was not limited to diabetes.</p> <p>A physician's recapitulation order, dated 9/1/14-9/30/14, indicated Resident #16 had blood glucose monitoring 4 times a day.</p> <p>Resident #18's record was reviewed on 9/22/14 at 4:45 p.m. Diagnosis included, but was not limited to diabetes.</p> <p>A physician's recapitulation order, dated 9/1/14-9/30/14, indicated Resident #18 had blood glucose monitoring 1 time a week.</p> <p>Resident #19's record was reviewed on 9/22/14 at 4:45 p.m. Diagnosis included, but was not limited to diabetes.</p> <p>A physician's recapitulation order, dated 9/1/14-9/30/14, indicated Resident #19 had blood glucose monitoring 4 times a day.</p> <p>Resident #26's record was reviewed on 9/22/14 at 4:50 p.m. Diagnosis included, but was not limited to diabetes.</p> <p>A physician's recapitulation order, dated 9/1/14-9/30/14, indicated Resident #26 had blood glucose monitoring 4 times a day.</p> <p>Resident #27's record was reviewed on 9/22/14 at 4:50 p.m. Diagnosis included, but was not limited to diabetes.</p>			

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	<p>A physician's recapitulation order, dated 9/1/14-9/30/14, indicated Resident #27 had blood glucose monitoring 4 times a day.</p> <p>Resident #30's record was reviewed on 9/22/14 at 4:55 p.m. Diagnosis included, but was not limited to diabetes.</p> <p>A physician's recapitulation order, dated 9/1/14-9/30/14, indicated Resident #30 had blood glucose monitoring 4 times a day.</p> <p>Resident #32's record was reviewed on 9/22/14 at 4:55 p.m. Diagnosis included, but was not limited to diabetes.</p> <p>A physician's recapitulation order, dated 9/1/14-9/30/14, indicated Resident #32 had blood glucose monitoring 1 time a day.</p> <p>Resident #38's record was reviewed on 9/22/14 at 5:00 p.m. Diagnosis included, but was not limited to diabetes.</p> <p>A physician's recapitulation order, dated 9/1/14-9/30/14, indicated Resident #38 had blood glucose monitoring 2 times a week.</p> <p>Resident #51's record was reviewed on 9/22/14 at 5:00 p.m. Diagnosis included, but was not limited to diabetes.</p> <p>A physician's recapitulation order, dated</p>			

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	<p>9/1/14-9/30/14, indicated Resident #51 had blood glucose monitoring 1 time a day.</p> <p>Resident #61's record was reviewed on 9/22/14 at 5:05 p.m. Diagnosis included, but was not limited to diabetes. A physician's recapitulation order, dated 9/1/14-9/30/14, indicated Resident #61 had blood glucose monitoring 1 time a week.</p> <p>Resident #62's record was reviewed on 9/22/14 at 5:05 p.m. Diagnosis included, but was not limited to diabetes. A physician's recapitulation order, dated 9/1/14-9/30/14, indicated Resident #62 had blood glucose monitoring 1 time a day.</p> <p>Resident #65's record was reviewed on 9/22/14 at 5:10 p.m. Diagnosis included, but was not limited to diabetes. A physician's recapitulation order, dated 9/1/14-9/30/14, indicated Resident #65 had blood glucose monitoring 4 times a day.</p> <p>Resident #73's record was reviewed on 9/22/14 at 5:10 p.m. Diagnosis included, but was not limited to diabetes. A physician's recapitulation order, dated 9/1/14-9/30/14, indicated Resident #73</p>			

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	<p>had blood glucose monitoring 4 times a day.</p> <p>Resident #74's record was reviewed on 9/22/14 at 5:15 p.m. Diagnosis included, but was not limited to diabetes. A physician's recapitulation order, dated 9/1/14-9/30/14, indicated Resident #74 had blood glucose monitoring 1 time a day.</p> <p>Resident #90's record was reviewed on 9/22/14 at 5:15 p.m. Diagnosis included, but was not limited to diabetes. A physician's recapitulation order, dated 9/1/14-9/30/14, indicated Resident #90 had blood glucose monitoring 1 time a day.</p> <p>Resident #121's record was reviewed on 9/22/14 at 5:20 p.m. Diagnosis included, but was not limited to diabetes. A physician's recapitulation order, dated 9/1/14-9/30/14, indicated Resident #121 had blood glucose monitoring 1 time a day.</p> <p>Resident #122's record was reviewed on 9/22/14 at 5:20 p.m. Diagnosis included, but was not limited to diabetes. A physician's recapitulation order, dated 9/1/14-9/30/14, indicated Resident #122 had blood glucose monitoring 2 times a</p>			

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	<p>day.</p> <p>On 9/24/14 at 4:00 p.m., the Administrator provided a document, titled, "Ultra Trak Pro Sample Policy Procedures," dated March 2012. The policy indicated the blood glucose monitor should have been cleaned and disinfected between each test with EPA (Environmental Protection Agency) registered germicidal or bleach wipe. A policy titled, "Glucometer cleaning," dated 7/1/11, and identified as current was provided by the DON on 9/22/14 at 3:20 p.m. The policy indicated, "...Complete sanitization of glucometers by wiping with approved disposable wipes between resident use. Discard wipes in appropriate receptacle. There should be 2 glucometers per medication cart-one in use and one cleaned and drying ...." The DON indicated the glucometer should remain wet with sanitizing wipe for 2 minutes and then air dry.</p> <p>The immediate jeopardy that began on 9/22/14 was removed on 9/25/14 when the facility removed the improper sanitizer wipes from the facility, and acquired EPA (Environmental Protection</p>			

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	Agency) registered disinfectant wipes for glucometer cleaning. The facility implemented a new policy and procedure for cleaning/disinfecting/maintaining glucose meters, that specified the approved sanitation wipes, included directions for use and indicated any resident with a known communicable disease would have a glucometer designated for their use only, and in-serviced RN's (Registered Nurses), LPN's (Licensed Practical Nurses) and QMA's (Qualified Medication Aides) to the policy and procedure. The facility implemented a system for monitoring/auditing to ensure proper cleaning/disinfection of the blood glucose meter. The noncompliance remained at a lower scope and severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy because of the ongoing monitoring to ensure compliance with the new policy/procedure. 3.1-18(a)				