

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155251	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/12/2012
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342
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F0000	<p>This visit as for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 9, 10, 11, and 12, 2012</p> <p>Facility number: 000154 Provider number: 155251 AIM number: 100289680</p> <p>Survey team: Regina Sanders, RN, TC Marcia Mital, RN Kelly Sizemore, RN Sheila Sizemore, RN (January 10, 11, and 12, 2012 Susan Bruck, RN</p> <p>Census by bed type: SNF/NF: 65 SNF: 11 Total: 76</p> <p>Census payor type: Medicare: 14 Medicaid: 57 Other: 5 Total: 76</p> <p>Sample: 16 Supplemental sample: 14</p>	F0000		

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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	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 13, 2012 by Bev Faulkner, RN</p>				

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow physician's orders related to restorative nursing and fall interventions for 1 of 16 residents reviewed for physician's orders in a total sample of 16. (Resident #27)</p> <p>Findings includes:</p> <p>Resident #27's record was reviewed on 1/10/12 at 11:11 a.m. Resident #27's diagnoses included, but were not limited to, stroke and heart failure.</p> <p>A physician's telephone order, dated 12/22/11, indicated "Pt (patient) d/c'd (discharged) from P.T. 12/21/11. Pt to continue with restorative nursing."</p> <p>A Physical Therapy plan of care, dated 12/21/11, indicated "...Ambulates 15-20 ft (feet) using a RW (rolling walker) mod A (moderate assist) with vc (verbal cueing) to initiate proper posture, gait and safety. Res (Resident) to cont. (continue) with restorative program to maintain current function."</p>	F0282	<p>It is the policy of Miller's Merry Manor, Hobart to ensure services provided by or arranged by the facility be provided by qualified persons in accordance with each resident's written plan of care. Resident # C: Continues with therapy services and as of 1/10/2012 a hoyer lift for all transfers completed per nursing. C.N.A. #1 is no longer employed. All residents with a physician's order to transfer utilizing two staff were at risk to be affected by the deficient practice. Physician orders for residents were reviewed by the DON or other nurse manager by 2/13/2012. How each resident transfers and the amount of assist required for transfer shall be included in the written plan of care. All residents will be reviewed by the DON or other nurse manager to determine the required assistance needed for transfer. HCP will be updated to reflect the transfer ability of each resident and the amount of staff assistance required for transfer. An all staff in-service was held on to discuss the importance of following each residents individual plan of care. The C.N.A.assignment sheets shall</p>		

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	<p>Resident #27's record lacked documentation of the resident being placed on a restorative program.</p> <p>During an interview on 1/10/12 at 2:00 p.m., the Restorative LPN, indicated the resident had not been placed in a restorative program for ambulation.</p> <p>During an interview on 1/10/12 at 2:40 p.m., the Restorative LPN, indicated she had spoken with the therapist who would show her what type of program the resident needed.</p> <p>3.1-35(g)(2)</p>		<p>serve as the communication device for nursing staff to know what the transfer needs are for each resident and the minimum amount of assistance required to complete safe transfer. The therapy department and restorative nurse/C.N.A. will continue to review each residents transfer ability quarterly and with any significant change in status to ensure HCP interventions for transfer to ensure adequate support is provided to each resident with transfers. Any identified changes in plan of care related to transfers shall be promptly updated on the C.N.A. assignment sheets to ensure continuity of care. The DON or designee will observe transfers to ensure proper transfer technique and staff assistance provided with each observation. The quality assurance tool "Transfer Review" (Attachment A) will be completed on 5 residents weekly for six weeks then monthly thereafter to monitor for ongoing compliance. Any identified trends will be corrected and logged on a facility tracking log. The tracking log will be discussed/reviewed during the monthly facility quality assurance meeting to ensure compliance. The facility conducts a job specific orientation process to ensure all new nursing staff are checked off on the proper use of mechanical lifts, gaitbelts, and following each residents plan of care.</p>		

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F0311 SS=D	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident received restorative services for ambulation as ordered by the physician for 1 of 16 residents reviewed for restorative services in a total sample of 16. (Resident # 27)</p> <p>Findings includes:</p> <p>Resident #27's record was reviewed on 1/10/12 at 11:11 a.m. Resident #27's diagnoses included, but were not limited to, stroke and heart failure.</p> <p>A physician's telephone order, dated 12/22/11, indicated "Pt (patient) d/c'd (discharged) from P.T. 12/21/11. Pt to continue with restorative nursing."</p> <p>A Physical Therapy plan of care, dated 12/21/11, indicated "...Ambulates 15-20 ft (feet) using a RW (rolling walker) mod A (moderate assist) with vc (verbal cueing) to initiate proper posture, gait and safety. Res (Resident) to cont. (continue) with restorative program to maintain current function."</p>			F0311	<p>It is the policy of Millers Merry Manor, Hobart to ensure the services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Resident #27: Restorative nurse and lead therapist reviewed the chart promptly when alerted that restorative program had not been implemented as ordered. A restorative program was written, implemented, and added to plan of care. Restorative aide trained on the program. Program has been in place since 1/11/2012. All residents with orders for a restorative nursing program are at risk to be affected by the deficient practice. A chart audit was conducted on 1/10/12 and 1/11/12 by the restorative nurse and lead therapist. Residents who had received therapy services in the past 60days were reviewed to ensure no other physician orders for restorative programs had not been missed. An in-service was held with the lead therapist, restorative nurse, MDS coordinator, and restorative aides on 1/26/12 to review the facility policy for "Restorative Nursing".</p>		02/01/2012

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	<p>Resident #27's record lacked documentation of the resident being placed on a restorative program.</p> <p>During an interview on 1/10/12 at 2:00 p.m., the Restorative LPN, indicated the resident had not been placed in a restorative program for ambulation. She indicated the resident was discharged from therapy and restorative was to ambulate the resident. She indicated she would look for the paper therapy had given her.</p> <p>During an interview on 1/10/12 at 2:40 p.m., the Restorative LPN, indicated she had spoken with the therapist who would show her what type of program the resident needed.</p> <p>During an interview on 01/10//12 at 2:43 p.m., the Physical Therapist indicated the resident had been walking in therapy and was discharged to Restorative Nursing.</p> <p>During an observation on 1/10/12 at 2:43 p.m., Resident #27 was observed to be ambulated by the physical therapist 15 feet.</p> <p>3.1-38(a)(2)(B)</p>		<p>The restorative aides are responsible to report functional declines or resident refusals to the restorative nurse for follow up. The facility has a weekly therapy meeting with the HCP team to review all residents receiving therapy services. During this weekly meeting the team discusses dates for upcoming resident discharge and any plans for implementing a formal restorative program upon discharge. The lead therapist and restorative nurse will begin to create, implement, and train restorative aides on new formal restorative program approx. 1 week prior to the actual date of discharge from therapy. The restorative nurse is responsible to document quarterly assessments on all formal restorative nursing programs to ensure that residents are maintaining/enhancing overall functional status. The restorative nurse or MDS coordinator will be responsible to complete the quality assurance tool "Restorative Rehab Review" (Attachment A) on 5 residents weekly for six weeks then monthly thereafter to monitor for ongoing compliance. Any identified trends will be corrected and logged on a facility tracking log. The tracking log will be discussed/reviewed during the monthly facility quality assurance meeting to ensure compliance.</p>		

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F0328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>A. Based on observation, record review, and interview, the facility failed to ensure a resident's oxygen was on as ordered by the physician, for 1 of 2 residents reviewed with oxygen in a total sample of 16. (Resident #56)</p> <p>B. Based on observation, record review, and interview, the facility failed to follow the physician's orders to maintain a residents PICC (Peripherally Inserted Central Catheter) related to assessing, cap changes, dressing changes, and measuring extra length, for 1 of 3 residents reviewed with PICC's in a total sample of 16. (Resident #71)</p> <p>Findings include:</p> <p>A.1. Resident #56's record was reviewed on 1/10/12 at 9:35 a.m. Resident #56's diagnoses included, but were not limited</p>	F0328	<p>It is the policy of Miller's Merry Manor, Hobart to ensure that residents receive proper treatment and care for special services such as oxygen therapy and Intravenous therapy. Resident #71 has been discharged from facility Resident #56: Resident has physicians order for oxygen at 2L/min via nasal cannula continuously. Charge nurses are responsible for applying and setting oxygen liters. Resident will receive oxygen as ordered by the physician. All residents with an I.V. or with orders for oxygen therapy are at risk to be affected by the deficient practice. An all nursing staff in-service was held on 1/20/12 to review facility policy for care of a resident with an I.V., oxygen administration, and importance of providing treatments as ordered by the physician. The DON reviewed all resident charts for those with orders for oxygen use and/or with an IV on 1/22/2012 to ensure</p>	02/01/2012			

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	<p>to, diabetes, congestive heart failure, and chronic obstructive pulmonary disease.</p> <p>A physician's order, dated 12/7/11, indicated oxygen at 2 liters per minute per nasal cannula continuously.</p> <p>During an observation on 1/10/12 at 9:10 a.m., Resident #56 was in her wheelchair in the hallway and her oxygen was on 3 liters per nasal cannula.</p> <p>During an observation on 1/10/12 at 9:45 a.m., Resident #56 was in her wheelchair in her room and her oxygen was on at 3 liters per nasal cannula.</p> <p>During an observation on 1/10/12 at 10:10 a.m., Resident #56 was in her wheelchair in the hallway and her oxygen was on at 3 liters per nasal cannula.</p> <p>During an interview at the time of the observation, CNA #6 indicated "I believe it's suppose to be on 3 liters."</p> <p>During an observation on 1/10/12 at 10:12 a.m. with LPN #7, she indicated Resident #56 was on 3 liters but she believed she was suppose to be on 2 liters. LPN #7 checked the physician's order and indicated, "Yes she should be on 2 liters."</p> <p>A facility policy titled "Oxygen</p>		<p>that care is being provided as indicated on HCP and as ordered by the physician. Charge nurses are responsible for turning oxygen on and setting the liter flow for administration for residents with orders for oxygen therapy. Charge nurses participate in routine walking rounds on assigned units and will be responsible to check that oxygen is set on correct liter flow and applied as ordered by physician a minimum of 2x per shift. C.N.A. assignment sheets serve as communication device for nursing assistants to be aware that resident requires oxygen therapy. Nurse aides have been instructed to notify charge nurses when a resident needs to be switched between oxygen therapy delivery devices such as concentrator vs. portable tank. Residents who are receiving I.V. therapy will have a plan of care that includes every shift observations of IV site for signs and symptoms of infection, or infiltration. Additional physician orders for the basic care for dressing changes, site rotation, cap changes, flushes etc... will be obtained from the physician and implemented as ordered by physician. The residents MAR and/or Daily assessment may serve as evidence that the shift site assessments are completed per policy. During in-service on 1/20/2012 the importance of</p>				

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	<p>Administration Protocol," dated 12/1/10, and received as current from the DoN (Director of Nursing) on 1/12/12 at 9:30 a.m., indicated "1...Oxygen is authorized for use by the physician...2. Indications: Administration of oxygen, l/pm (liters per minute) and type of delivery system is based on a physician order..."</p> <p>B.1. Resident #71's record was reviewed on 1/9/12 at 12:50 p.m. Resident #71's diagnoses included, but were not limited to diabetes, decubitus ulcer infection, and hypertension.</p> <p>Physician's orders, dated 12/22/11 indicated the following:</p> <p>IV-assess site Q (every) shift and prn (as needed)-monitor for signs or symptoms infiltration and infection, change blue T adaptor to all lumens of PICC every 3 days, change injection cap every 7 days and prn with dressing change, change transparent dressing Q 7 days and prn, and measure extra length (PICC) daily.</p> <p>An IV (intravenous) Administration Record, dated January 2012, indicated the PICC line was only assessed during the day shift on 1/1 and 1/2 and the extra length was measured on the day shift on 1/1 and 1/2.</p>		<p>signing off MAR's when assessment of I.V. site and oxygen level monitoring occurs to serve as documented evidence that the assessment has been completed per plan of care. The D.O.N or other designee will be responsible to complete the quality assurance tool "Special Services" (Attachment B) daily for 10days, then 3x weekly for 4 weeks, then weekly x4 weeks and then monthly thereafter to monitor for ongoing compliance. Any identified issues will be corrected immediately and then logged on QA tracking log for review during the facility monthly quality assurance meeting.</p>				

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	<p>The IV Administration Record, dated January 2012, lacked documentation the PICC line was assessed every shift, the dressing had been changed every 7 days (was due 1/4/12), the injection cap was changed (was due 1/4/12), and the blue T adaptors were changed every 3 days (were due 1/3/12 and 1/6/12).</p> <p>During an observation on 1/9/12 at 2:15 p.m., Resident #71 was noted to have a PICC (Peripherally Inserted Central Catheter) to his left arm with the date of 12/28/10 on the dressing.</p> <p>During an interview on 1/9/12 at 2:16 p.m. with LPN #4, she indicated the dressing should have been changed on 1/4/12.</p> <p>A facility policy titled "Care, Maintenance and Removal of the Peripherally Inserted Central Catheter," dated 1/20/05 and received as current from the DoN on 1/10/12 at 10:20 a.m., indicated "...Policies and Guidelines:...3. Physician must order all procedures which specifically apply to P.I.C.C lines, such as tip placement, flushing, or dressing changes...5. Transparent dressing...changed at least once a week..."</p> <p>3.1-47(a)(2) 3.1-47(a)(6)</p>						

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F0441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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 - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</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, record review and interview, the facility failed to follow</p>	F0441	This plan of correction is our written allegation of compliance in	02/01/2012	

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	<p>standard precautions during the performance of routine testing of blood glucose levels, related to disinfecting a blood glucose monitor (checks blood sugars) between obtaining resident's blood sugars during two observations of blood sugar monitoring, resulting in a risk of transmission of blood borne pathogens for 1 of 2 residents observed in a supplemental sample of 14 (Residents #42 and #47). In addition to the resident in immediate jeopardy, the facility failed to ensure nurses in the facility were knowledgeable of the facility's policy and procedure for disinfecting the blood glucose monitors to prevent the transmission of blood borne pathogens. This had the potential to affect 16 residents who received blood glucose monitoring out of a total population of 76 in the facility.</p> <p>The Immediate Jeopardy began on 01/09/12 when RN #1 was observed completing a blood sugar check on a resident and failed to disinfect the blood glucose monitor in between checking residents' blood sugars. The Administrator, Director of Nursing (DoN), and Director of Support Services were notified of the immediate jeopardy at 6 p.m. on 01/09/12. The immediate jeopardy was removed on 01/11/12 at 3:05 p.m., but noncompliance remained at</p>		<p>response to the notification that the ISDH determined Miller's Merry Manor, Hobart to be in "Immediate Jeopardy" per notification on 1/9/2012 at approximately 6:30p.m. Please note that the submission of this plan of correction is not an admission that a deficiency exists, but is merely submitted to meet the requirements established by the state and federal law. It is the policy of Miller's Merry Manor, Hobart to 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. The nurse identified by the ISDH as not following the facility policy for glucometer disinfecting 1/9/12 was immediately retrained and required to perform a return demonstration on the proper procedure for completing glucose monitoring to ensure that disease/infection are not transmitted via use of glucometers. All residents who receive blood sugar monitoring are at risk to be affected by the deficient practice. Immediately following the exit conference with the ISDH on 1/9/2012 all charge nurses in the facility were given a face to face in-service that included return demonstration of proper glucometer disinfecting,</p>				

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	<p>the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include:</p> <p>During an observation on 01/09/12 at 4:05 p.m., RN #1 was outside Resident #47's room. RN #1 removed the glucose monitor (glucometer) from the medication cart, inserted a test strip into the glucometer, and then entered the resident's room. RN #1 applied gloves, then swabbed the resident's finger with an alcohol prep pad and pricked the resident's finger with a lancet to obtain a blood sample. RN #1 then placed the blood sample on the test strip in the glucometer. RN #1 obtained the blood glucose level and walked back out into the hallway with the glucometer, removed her gloves, and placed the glucometer on top of the medication sheets setting on the medication cart. RN #1 did not wash her hands before leaving the resident's room. RN #1 then moved the cart down the hallway outside of Resident's #55 and #56's door. The door to the resident's room was closed. RN #1 indicated both residents were scheduled for a glucometer check. She indicated the residents were receiving care at that time so she could not check their blood sugars. The</p>		<p>glucose monitoring procedure(Attachment C), and prevention of transmission of disease/infection via the use of glucometers (Attachment D). The facility contacted nurses not on the schedule to come and participate in a face to face in-service training on 1/9/2012 at 8:20p.m. that included return demonstration of proper glucometer disinfecting, glucose monitoring procedure, and prevention of transmission of disease/infection via the use of glucometers. Prior to the beginning of the 3 rd shift charge nurses reporting to unit on 1/9/2012 at 10:30p.m. the DON and Corporate Quality Nurse provided a face to face in-service that included return demonstration of proper glucometer disinfecting, glucose monitoring procedure, and prevention of transmission of disease/infection via the use of glucometers. The DON or other designee will continue to provide face to face in-service training to all nurses reporting to work thru 1/10/2012 8a.m. Any charge nurse or QMA who has not received face to face retraining by 1/10/2012 8am regarding the deficient practice will not be permitted to work until the face to face in-service is completed with return demonstration. Additionally, an all staff in-service was held on 1/20/2012 to review basics of infection control and</p>		

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	<p>glucometer was still laying on top of the medication sheets on the cart.</p> <p>Further observation on 01/09/12 at 4:15 p.m., indicated RN #1 then moved the medication cart back down the hallway, outside of Resident #42's room. RN #1 indicated the resident was scheduled for a glucometer check. RN #1 then picked up the glucometer, placed a testing strip in the glucometer, and obtained a lancet and entered Resident #42's room to obtain the resident's blood glucose level. RN #1 still had not washed her hands since leaving Resident #47's room. RN #1 was stopped before the blood glucose test could be performed.</p> <p>During an interview at the time of the observation, RN #1 indicated, "probably," when inquired about the disinfecting of the glucometer. RN #1 then returned to the medication cart, removed a disinfectant wipe from the container, wiped down the glucometer for 45 seconds and then reentered the resident's room to obtain a blood glucose level on Resident #42.</p> <p>During an interview on 01/09/12 at 5 p.m., LPN #2 indicated the glucometers are cleaned every time they are used. She indicated the Central Unit has two glucometers and they rotate the usage</p>		<p>prevention of the spread of infection thru hand-washing. The specifics of facility hand-washing policy and how to complete proper hand-washing technique was reviewed. All newly hired charge nurses or QMA's must participate in a 11day orientation process which includes the use and disinfection process for the glucometers. New hires will not participate in blood sugar monitoring until employee has successfully completed the required job specific orientation skill for glucose monitoring and disinfecting glucometers. A laminated copy of the glucometer disinfecting policy and procedure will be placed in all diabetic unit books. The DON or other nursing designee will be responsible to observe at least 2 glucometers per unit (if orders exist for the unit) on each shift for the next 7days, then daily observation of 2 glucometers for another week, then biweekly for the next 6weeks and monthly thereafter to ensure ongoing compliance. The QA monitoring tool titled "Glucose Machine Review" (Attachment E) will be completed weekly for the next 6 weeks then monthly thereafter. Any identified issues will be corrected immediately and then logged on QA tracking log for review during the facility monthly quality assurance meeting. Completion 1/10/2011 at 8:45a.m.</p>		

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	<p>every other one. She indicated she wipes the glucometer down with alcohol prep pads. She indicated the facility policy for disinfecting the glucometer is to use the alcohol prep pads to wipe down the glucometer.</p> <p>During an interview on 01/09/12 at 5:05 p.m., LPN #4 indicated the policy says to use a wipe and wipe down the glucometer for 10-20 seconds before and after each use.</p> <p>During an interview on 1/9/12 at 5:05 p.m., LPN #5 indicated she cleaned the glucometer after use on each resident with an alcohol pad.</p> <p>During an interview on 01/09/12 at 6 p.m., the DoN indicated the disinfectant wipes should be used for two minutes.</p> <p>The facility policy, dated 12/23/09, titled, "Cleaning of Glucometer", and received as current from the DoN, indicated, "...A. After completing a blood sugar on one resident and before doing a blood sugar on another resident, use a commercial disinfectant wipe..and completely wipe down the glucometer so it is visibly wet... C. Follow manufacturer's instructions related to length of time to disinfect before reusing. Air dry time is around 30 seconds, so you must rewet the meter or</p>		of the initial POC to request removal/abaitment of the Immediate Jeopardy.		

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	<p>wrap the wet wipe around the meter after wiping it down to ensure the proper contact time is achieved as directed by the manufacturer. D. Wait and allow to air dry before re-using the glucometer."</p> <p>The manufacturer's instructions for the Disinfecting Wipes, received from the DoN on 01/09/12 at 5 p.m., indicated the wipes kills the following pathogens at room temperature: HIV after one minute, Hepatitis B, Hepatitis C, Tuberculosis, Staphylococcus aureus, Pseudomonas aeruginosa, Salmonella, Methicillin Resistant Staphylococcus aureus, Vancomycin Resistant Enterococcus faecium, Influenza A, Herpes simplex virus 2 after two minutes, and other pathogens after five minutes.</p> <p>The manufacturer's instructions for the glucometer, received from the DoN on 01/11/12 at 9 a.m., indicated, "...Disinfecting Guidelines: To disinfect the meter, dilute 1 mL (milliliter) of household bleach in 9 mL of water to achieve 1:10 dilution...Please note that there are commercially available 1:10 bleach wipes from a variety of manufacturers..." The guidelines indicated there were germicidal products also acceptable to disinfect the meters. The manufacturer's instructions continued</p>				

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	<p>to indicate, "...To use these products, remove a wipe from the container and follow product label instructions to disinfect meter..."</p> <p>The immediate jeopardy that began on 01/09/12 was removed on 01/11/12 when the facility immediately inserviced all the Charge Nurses in the facility, which included a return demonstration of the proper glucometer disinfecting, glucose monitoring procedure, and prevention of transmission of disease/infection by the glucometer. The facility then contacted all of the Nurses and QMA's to come into the facility to also receive the inservice. The facility indicated any Nurse or QMA who has not received the inservice would not be permitted to work until the inservice is completed and a return demonstration was done. The DoN documented policy and procedure inservices and return demonstrations had been completed on 17 of 23 nurses and 2 of 5 QMA's. Quality Assurance monitoring was initiated to ensure staff followed the facility's policy for disinfecting the glucometer. Four nurses and one QMA was observed completing glucometer checks on 01/10/11 and 01/11/11 and were able to demonstrate correct disinfection of the glucometer meter, but the noncompliance remained at the lower scope and severity level of</p>				

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	<p>pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy as the DoN or her designee will continue to observe the Nurses' and QMA's for compliance with the policy for disinfecting the glucometers for two glucometers checks on each shift for the next seven days, then daily for a week, then biweekly for the next six weeks and then monthly. A Quality Assurance tool will be completed weekly for the next six weeks and then monthly and will be reviewed during the facility monthly Quality Assurance meeting.</p> <p>3.1-18(a)</p>			