STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155532	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOMINGTON NURSING AND REHABILITATION CENTER	120 E MILLER DR BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: March 5, 6, 7 and 8, 2012 Facility number: 000460 Provider number: 155532 AIM number: 100290620 Survey Team: Marla Potts, RN, TC (March 5, 6, 7, 2012) Sharon Whiteman, RN Susan Worsham, RN Census bed type: SNF/NF 24 Total 24 Census payor type: Medicare 3 Medicaid 19 Other 2 Total 24 Sample: 10 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review 3/15/12 by Suzanne	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Williams, RN			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on observation, interview, and record review, the facility failed to ensure nursing staff notified a resident's family and physician of changes in the resident's condition, for 1 of 5 residents reviewed	F0157	**Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies.**	04/07/2012

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	for notification in a sample of 10. (Resident #3) Findings Include: On 03/06/12 at 11:30 a.m. CNA #1 and CNA #2 were observed to provide incontinence care for Resident #3. The CNAs were observed to remove a wet brief and to position the resident on his left side. The resident's bottom was observed to be red and to have 3 superficial open areas on his left lower buttocks, 1 open area on his left posterior leg, and 3 superficial open areas on his left outer buttocks. The CNAs were observed to transfer the resident from his bed to a Broda chair and to propel the Broda chair to the dining room. Interview of CNA #1 on 03/07/12 at 9:20 a.m. indicated she had just provided care for Resident #3 and the resident still had the same open areas as "yesterday." Interview of LPN #1 (working hall Resident #3 resided on) on 03/07/12 at 9:25 a.m. indicated she was not aware Resident #3 had open areas. LPN #1 indicated CNAs are supposed to notify their nurse when any resident has a change or any new open areas. LPN #1 indicated she was aware Resident #3 had a reddened and excoriated bottom but was		**This plan of correction is prepared and/or executed solely because required.** **F 157 Notify of Changes** **(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:** Resident # 3: The MD/Family was notified of open areas to buttocks, orders received for treatment, and care plan updated. CN A 's # 1 and # 2 identified having provided care for Resident # 3 on 3/6/12 and not reporting the open area(s), were re- educated by a teachable moment on reporting skin issues to the licensed nurse at time of observation. **(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:** A facility skin sweep will be completed, to assess current residents for any unidentified pressure ulcer/ skin issues requiring treatment and proper MD/family notification. **(c)What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** Nursing staff were re-educated regarding reporting of any identified pressure ulcer/skin issues to the licensed nurse and the MD/Family notification of any identified pressure ulcers/open skin areas requiring treatment.	

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	not aware the resident had open areas. The LPN indicated the resident had Calazyme ointment (barrier cream) in his drawer and she or the CNAs could apply the cream as needed. On 03/0712 at 11:05 a.m. with the DON [Director of Nursing] present, CNA #1 was observed to remove Resident #3's adult brief and repositioned the resident on his side. The DON counted 8 open areas. The resident had 3 areas on his left buttocks, 3 areas on his right lower buttocks, and 2 open areas on his upper/inner buttocks. Review of Resident #3's clinical record on 03/05/12 at 10:55 a.m. indicated the following: A nurse's note, dated 03/06/12 at 12:00 p.m., indicated, "[Nurse Practitioner's name]...for [physician's name] here to see Res et review case - Res presents c swelling et redness to RLE [right lower extremity] foot & toe areas slightly warm to touch - upon assessment N.O. [new order] received for ATB [antibiotic] therapy....Placed call to Res wife to report above - left voice message." Although the Nurse Practitioner was present at the facility on 03/06/12 she was not made aware of any concerns Resident		The nursing staff will place any identified pressure ulcer / skin issue on the 24 hour report with time of MD/Family notification and treatment for pressure ulcer/ skin issue. This will be discussed at the next morning meeting and to ensure that the plan of care has been updated to reflect these changes. **(d)How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:** DNS /Designee will complete random skin checks on 5 residents weekly in conjunction to weekly skin checks to ensure that any/all new skin issues have been addressed timely. Along with this will be the review of the 24 hour report to identify any pressure ulcers/skin issues, check for MD/Family notification, and for new treatment orders. The above plan focus will continue for 4 weeks then bi-weekly for two months. Report of the audits will be presented to the Risk Management/QA meeting to ensure compliance remains and that it is recommended that oversight monitoring will be done quarterly by the RDCO when system review is completed which includes MD/Family notification of newly identified ulcers. **Date of compliance:** 4/7/12	

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	#3 had other than redness to his right lower extremity. A "Change in a resident's Condition or Status Policy Statement" with a "Revised" date of 2006 was provided by the DON on 03/08/12 at 1:00 p.m. The policy indicated, "Our facility shall promptly, notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status...The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been:...A significant change in the resident's physical...condition...Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative (sponsor) when:...There is a significant change in the resident's physician...condition." As of exit on 3/08/12, the facility did not provide documentation supporting the physician and family were notified of changes in the resident's condition. 3.1-5(a)(2)			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation and record review, the facility failed to ensure nursing staff turned and repositioned a dependent resident according to the resident's care plan. This finding affected 1 of 5 residents reviewed for pressure ulcers in a sample of 10. (Resident #3) Findings Include: On 03/05/12 Resident #3 was observed seated in his Broda chair at 11:15 a.m., 12:10 p.m., 2:00 p.m., and 2:30 p.m. Resident #3 was observed to remain seated in his Broda chair on 03/06/12 at 11:30 a.m. 2:35 p.m., 3:00 p.m., 4:00 p.m. and 5:00 p.m. Review of Resident #3's clinical record on 03/05/12 at 10:55 a.m. indicated the following: Resident #3 had diagnoses which included, but were not limited to, brain injury, persistent vegetative state, type 2 diabetes, encephalopathy, and dysphagia (swallowing difficulty).	F0282	Preparation and/or execution of this plan do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. **F-282** the services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. **a.) What corrective action will be accomplished for those residents found to have been affected by this practice:** Resident #3 plan of care reviewed with updates made to the C.N.A. care card. **b.) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken:** Audit conducted of MDS to identify dependent residents for positioning with assurance the careplans and C.N.A. care cards	04/07/2012

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	A "Skin Risk Analysis" sheet, dated 12/07/11, indicated Resident #3 was a high risk for skin breakdown due to diagnosis of Diabetes, chronic bowel and urinary incontinence, head of bed elevation due to medical necessity (Resident received all nutrition via gastrostomy tube feeding), decreased mental awareness, and history of pressure ulcers. A nurse's note dated 12/27/11 at 10:32 p.m. indicated, "Total care for ADL's [activities of daily living]....turned q [every] 2 [symbol for hours]. Peri care given c incont [incontinent] episodes....HOB (head of bed) Glycotrol [feeding supplement]...via pump." A quarterly MDS [minimum data set] assessment, dated 12/29/11, indicated Resident #13 was in a persistent vegetative state with severe cognitive impairment; Resident #13 required total assistance from staff for personal hygiene, bathing, and transfers and repositioning; Resident #13 was incontinent of both bowel and bladder. A care plan, dated 10/28/10 with a most recent update of 03/07/12, indicated, "Resident has a potential for complications associated with urinary		appropriately reflect degree of assistance needed for positioning of the dependent residents. **c.) What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur:** Nursing staff have been reeducated on components of wound and skin care with focus on turning and repositioning of the dependent residents and following the care plan.. C.N.A. care cards have been reviewed and updated as per resident's care plan. **d.) How will the corrective action(s) be monitored to ensure the practice will not recur, what quality measures will be put into place?** DNS/designee will observe identified dependent residents on 3 separate occasions daily 3 times a week for 4 weeks then biweekly for 4 weeks.. Results of audits will be reported at the monthly Risk management/quality assurance meetings with oversight by the RDCO when completing the quarterly system review which includes review of wound and skin care. **e.) Date of compliance: 4/7/12**	

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	incontinence....skin breakdown....R/T [related to] Totally incontinent....Check at least every two hours around the clock to and (sic) provide the necessary assistance to keep resident clean and dry." A care plan, dated 12/07/11 with a most recent update of 03/07/12, indicated Resident #3 had a stage 2 pressure ulcer on his sacrum, a stage 3 pressure ulcer on his medial buttocks, and a stage 3 pressure ulcer on his left buttock. Approaches to this care plan included, but were not limited to, Notify nurse immediately of any new areas of skin breakdown, redness, blisters....noted during bathing or daily care....Provide pressure relieving or reduction device....Turn & repositioning program: Q [Every] 2 [symbol for hours] and PRN [as needed]. 3.1-35(g)(2)			

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F0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.			
	Based on observation, interview, and record review the facility failed to ensure a resident did not develop recurrent pressure ulcers and failed to ensure the areas were reported to the nurse and treated in a timely manner. This finding affected 1 of 5 residents reviewed for pressure ulcers in a sample of 10. (Resident #3) Findings Include: On 03/05/12 Resident #3 was observed seated in his Broda chair at 11:15 a.m., 12:10 p.m., 2:00 p.m., and 2:30 p.m. On 03/06/12 at 11:30 a.m. CNA #1 and CNA #2 were observed to provide incontinence care for Resident #3. The CNAs were observed to remove a wet brief and to position the resident on his left side. The resident's bottom was observed to be red and to have 3	F0314	**Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.** **F – 314 Pressure Ulcers** **(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:** Identified skin areas to resident #3 were re-assessed, wounds were measured and documented. Physician and family were notified and treatment orders obtained and remain in place. Care plan was reviewed and updated. **(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:** A facility wide “Skin Sweep” was completed on the active residents to observe for pressure ulcers and to assure that any pressure ulcers identified were correctly measured, appropriate treatments were	04/07/2012

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	superficial open areas on his left lower buttocks, 1 open area on his left posterior leg, and 3 superficial open areas on his left outer buttocks. There had been no dressings covering the areas. The CNAs were observed to transfer the resident from his bed to a Broda chair and to propel the Broda chair to the dining room. Interview of CNA #1 on 11:35 a.m. indicated, "(Resident #3's) (bottom) looks a lot better than it did." The CNA indicated Resident #3's family requests that the resident be up in his Broda chair until after his last meal when he is gotten up "this late." Resident #3 was observed to remain seated in his Broda chair on 03/06/12 at 2:35 p.m., 3:00 p.m., 4:00 p.m. and 5:00 p.m. Interview of CNA #1 on 03/07/12 at 9:20 a.m. indicated she had just provided care for Resident #3 and the resident still had the same open areas as "yesterday." Interview of LPN #1 (working hall Resident #3 resided on) on 03/07/12 at 9:25 a.m. indicated she was not aware Resident #3 had open areas. LPN #1 indicated CNAs are supposed to notify her when any resident has a change or any new open areas. LPN #1 indicated she		implemented, and documented accordingly. Care plans reviewed and revised as needed. No new areas were identified during the sweep. **(c)What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** Nursing Staff have been re-educated on the components of regulation F-314 regarding prevention of pressure areas and pressure reducing measures with a focus on turning and repositioning, off loading tissue management, and reporting to the licensed nurse any change in a resident's skin condition. Licensed nurses were educated on the facility's wound care program with a focus on those residents assessed to be at high risk for skin breakdown. DNS or Designee will observe turning and repositioning as well as identifying that pressure relieving devices are in place during daily facility rounds. **(d)How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:** Director of Nursing or Designee will randomly audit 5 residents with wounds their Treatment Records, Weekly Skin Review, and Wound Progress Record weekly for the next 30-days, then bi-weekly for two months thereafter. Findings will be reported monthly at Risk Management/QA Meetings with oversight by the by the RDCO when completing Quarterly Systems Review which includes review of wound and skin care.	

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	was aware Resident #3 had a reddened and excoriated bottom. LPN #1 indicated Resident #3 did have open areas "maybe a couple of months ago." LPN #1 indicated the areas had healed. LPN #1 indicated the resident had Calazyme (barrier cream) ointment in his drawer, and CNAs had access to this and were aware to use after incontinence care or when the resident's skin was reddened. On 03/07/12 at 11:05 a.m., with the DON [Director of Nursing], CNA #1 was observed to remove Resident #3's adult brief and repositioned the resident on his side. The DON counted 8 open areas. The resident had 3 areas on his left buttocks, 3 areas on his right lower buttocks, and 2 open areas on his upper/inner buttocks. Review of Resident #3's clinical record on 03/05/12 at 10:55 a.m. indicated the following: Resident #3 had diagnoses which included, but were not limited to, brain injury, persistent vegetative state, type 2 diabetes, encephalopathy, and dysphagia (swallowing difficulty). A "Doctor's Progress Note" dated 11/01/11, indicated Resident #3 had open areas on each buttock and "a large area of erythema around the site...Will continue c		**(e) Date of compliance: 04/07/12**	

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	[with] current treatment. Will suggest catheter at least until healing is complete..." A "Skin Risk Analysis" sheet, dated 12/07/11, indicated Resident #3 was a high risk for skin breakdown due to diagnosis of diabetes, chronic bowel and urinary incontinence, head of bed elevation due to medical necessity (Resident receives all nutrition via gastrostomy tube feeding), decreased mental awareness, and history of pressure ulcers. A nurse's note dated 12/27/11 at 10:32 p.m. indicated, "Total care for ADL's [activities of daily living]....turned q [every] 2 [symbol for hours]. Peri care given c incont [incontinent] episodes....HOB [symbol for elevated] Glycotrol [feeding supplement]...via pump." A physician's re-write order for February 2012 indicated an order, dated 10/12/11, for "Mupirocin (Bactroban) 2%- apply to open areas on sacrum and buttocks and apply dry protective dressing daily." A quarterly MDS [minimum data set] assessment, dated 12/29/11, indicated Resident #13 was in a persistent vegetative state with severe cognitive			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	impairment; Resident #13 required total assistance from staff for personal hygiene, bathing, and transfers and repositioning; Resident #13 was incontinent of both bowel and bladder. A nurse's note, dated 02/08/12 at 3:45 p.m., indicated, "Culture to Res [Resident #13's] buttocks obtain (sic) although diff [difficulty] to obtain as Res buttocks has healed significantly - only dryness c scar tissue & sl [slight] excoriation noted - wound DR [Doctor] will be here @ facility tomm [tomorrow] for assessment." A care plan, dated 10/28/10 with a most recent target date of 03/07/12, indicated, "Resident has a potential for complications associated with urinary incontinence....skin breakdown....R/T [related to] Totally incontinent....Check at least every two hours around the clock to provide the necessary assistance to keep resident clean and dry." A care plan, dated 12/07/11 with a most recent target date of 03/07/12, indicated Resident #3 had a stage 2 pressure ulcer on his sacrum, a stage 3 pressure ulcer on his medial buttocks, and a stage 3 pressure ulcer on his left buttock. Approaches to this care plan included, but were not limited to, Notify nurse			

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	immediately of any new areas of skin breakdown, redness, blisters....noted during bathing or daily care....Provide pressure relieving or reduction device....Turn & repositioning program: Q [Every] 2 [symbol for hours] and PRN [as needed]. A nurse's note, dated 03/06/12 at 12:00 p.m., indicated, "[Nurse Practitioner's name]...for [physician's name] here to see Res et review case - Res presents c swelling et redness to RLE [right lower extremity] foot & toe areas slightly warm to touch - upon assessment N.O. [new order] received for ATB [antibiotic] therapy....Placed call to Res wife to report above - left voice message." Although the Nurse Practitioner was present at the facility on 03/06/12, there was no documentation indicating she was made aware of any concerns for the resident, other than redness to his right lower extremity. A copy of a CNA "Job Description" with an "issue date" of 06/08 was provided by the Corporate Nurse on 03/07/12 at 10:13 a.m. The Job Description indicated,"....Must....report changes in resident condition to nurse in charge...." Interview of the DON on 03/08/12 at 2:12			

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	p.m. indicated Resident #3's physician was at the facility and looked at the resident's new wounds and the doctor indicated the areas were all superficial and to continue with Bactroban ointment and keep the resident off of his bottom. The DON indicated the areas were "better" today. As of exit on 3/08/12, the facility did not provide documentation supporting measurement of these areas nor did they provide documentation supporting physician had been called until after the DON was made aware of the areas on 03/07/12 at 9:20 a.m. 3.1-40(a)(2) 3.1-40(a)(3)			

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a 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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to ensure	F0441	Preparation and/or execution of this plan does not constitute admission	04/07/2012

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	infection control measures for disinfecting a Glucose monitoring machine between residents was followed, for 1 of 4 residents observed to receive glucose testing in the sample of 10. Resident #2, RN #1 Findings include: On 3/6/12 at 3:20 p.m., RN #1 was observed to pick up a glucometer from the medication cart and proceed in to Resident #2's room. RN #1 was observed to prick the resident's finger, obtain the drop of blood, and place on the glucometer strip. After obtaining the reading, RN #1 came back out into the hall and laid the glucometer back on the medication cart. RN #1 then was observed to prepare and administer Resident #2's insulin in his room. Upon returning to the medication cart, RN # 1 was observed to clean the glucometer with an alcohol wipe. During interview with RN# 1 at this same time, she indicated " I always have used an alcohol wipe." During interview with the MDS Coordinator (Minimum Data Set Coordinator), on 3/6/12 at 3:30 P.M., she indicated the nurses were to use "santi-wipes," to clean the glucometers. RN #1 at this time opened the med cart and a container of santi-wipes was observed in		or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F-441 Infection Control (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice? Facility Standard and Guideline was reviewed for blood glucose monitor cleaning using manufacturer's recommendations for the 2 minute wet time for effectiveness of wipes. Licensed staff member RN # 1 responsible for blood glucose monitor cleaning for resident #2 was re-educated regarding proper procedure for cleaning/disinfection of blood glucose monitor units and wet time between resident use and competency checked with Staff Development Educator. (b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: Residents residing in the facility requiring blood glucose monitoring have potential to be affected. An audit to identify residents requiring blood glucose monitoring was completed and no additional residents were identified to have been affected.	

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	the drawer. The container indicated the solution was effective against multiple organisms and designed for uses which included the cleaning of glucometers. On 03/06/12, at 5 p.m., the DON (Director of Nursing) presented the standards and guidelines for disinfecting glucometers issued 7-07. It stated that the equipment was to be wiped down with an EPA-registered detergent/germicide with tuberculocidal (TB) or HIB/HIV label. Also, the glucometer was to be wiped on the front, back and sides, and to be placed on a clean surface to air dry for at least 2 minutes before using it on another resident. Interview of RN #2 on 03/08/12 at 1:20 p.m. indicated she was aware to disinfect the Glucometer with the Santi-Wipes disinfectant according to facility policy. 3.1-18(j)		(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Licensed staff were re-educated on infection control standard and guideline for blood glucose monitor cleaning, disinfection and two minute wet time according to manufacturer's guidelines and competency evaluated.(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: Director of Nursing or designee will complete a random weekly times 4 weeks then bi-monthly times 2 months to ensure that blood glucose monitor devices are being cleaned and disinfected according to manufacturer's recommendations (the required 2 minute wet time) between resident use Results of all audits will be referred to the RM/QA committee with quarterly monitoring by the RDCO during systems review which includes infection control. (e) Date of compliance: 4/7/2012	