

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105842	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/12/2024
NAME OF PROVIDER OR SUPPLIER  Crescent Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5401 Sawyer Rd Sarasota, FL 34233	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30599</p> <p>Based on observation and interview the Facility failed to ensure a clean and sanitary environment by failing to ensure the carpets in the halls of the facility and several rooms in the facility (rooms 616, and 610) were clean and sanitized, failing to ensure the walls were free from streaks, gouges and peeling wallpaper (rooms 616, 614, 610, and 609) the privacy curtains in room [ROOM NUMBER] and 610 were free from stains, The roof was in good repair and the ceiling in room [ROOM NUMBER] was free from signs of leaking, also, the hand rails were free from worn areas, and the hand rails were free from dirt and debris throughout the facility.</p> <p>The findings included:</p> <p>On 9/11/24 at 10:30 a.m., stains were observed on the carpets throughout the 100, 200, and 300 hallways.</p> <p>On 9/11/24 at 11:20 a.m., stains were observed on the carpet in hallway in front of room [ROOM NUMBER].</p> <p>On 9/11/24 at 11:22 a.m., a large dark brown stain was observed on the floor room in room [ROOM NUMBER].</p> <p>On 9/11/23 at 11:25 a.m., a large brown stain was observed on the carpet in hallway in front of room [ROOM NUMBER].</p> <p>On 9/11/24 at 11:27 a.m., dark streaks were observed on the walls and cabinets in room [ROOM NUMBER]. The wallpaper over the A bed was observed to be peeling. The wall near the bathroom door had the drywall scuffed and metal was observed.</p> <p>On 9/11/24 at 11:29 a.m., the drywall in room [ROOM NUMBER] was observed to have gouges and was in disrepair. The privacy curtain was observed to have brown stains. The wall paper was observed peeling off the wall behind the A bed.</p> <p>On 9/11/24 at 11:32 a.m., there was large brown stains observed on the privacy curtain in room [ROOM NUMBER]. The wall near the bathroom door hall gouges to the drywall and there was a large stain on the carpet neat the bathroom door. There were dark streaks observed on the walls.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 9/11/24 at 11:33 a.m., there was a gouge observed on the drywall near the B bed closet in room [ROOM NUMBER]. The ceiling showed signs of a roof leak on the ceiling over the A bed.</p> <p>On 9/11/24 at 11:35 a.m., the handrails throughout the 600 and 700 halls were observed to have scuffs to the wood and there was dirt and debris built up behind the handrails on the 600 and 700 hallways.</p> <p>On 9/11/24 at 12:01 p.m., the Maintenance Director verified there were stains on the carpet throughout the building. He stated they had been replacing squares on the carpet to get rid of some of the stains. The Maintenance Director stated a lot of the carpet would have to be replaced to get rid of all the stains. The Maintenance Director verified the walls were in disrepair in room [ROOM NUMBER], 614, 610, and 609. The Maintenance Director verified there had been a roof leak in some of rooms on the 600 hall. He verified room [ROOM NUMBER] had had a roof leak that had been patched. The Maintenance Director said there was an estimate for the roofing company to come back to the facility and repair the roof completely. The Maintenance Director verified the hand rails throughout the facility had been scuffed with the wood being exposed on the rails in some areas.</p> <p>On 9/12/24 at 2:28 p.m., the Director of Housekeeping verified the stains on the privacy curtains in rooms [ROOM NUMBERS]. She stated they have to clean room [ROOM NUMBER] more frequently because the resident stains the curtain frequently. The Housekeeping Director verified there was a build-up of debris behind the handrails throughout the facility.</p> <p>Photographic evidence obtained.'</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 21322</p> <p>Based on observation, record review and staff interview, the facility failed to implement physician's ordered interventions to prevent the development of avoidable pressure ulcers for 1 (Resident #34) of 5 sampled residents identified at risk for development of pressure ulcers.</p> <p>The findings included:</p> <p>Review of the clinical record for Resident #34 revealed an admitted [DATE]. Diagnoses included left hemiplegia (paralysis of the left side of the body).</p> <p>The Admission Minimum Data Set (MDS) assessment with a target date of 8/15/24 noted Resident #34 was dependent on staff for mobility, including rolling left and right. At the time of the assessment, Resident #34 did not have a pressure ulcer but was at risk of developing pressure ulcers.</p> <p>Review of the Braden Scale for predicting Pressure Sore Risk (Standardized, evidence based assessment to predict the risk of developing pressure ulcers) for Resident #34 revealed on 8/31/24 the resident scored 8 on the assessment, indicating a very high risk for development of pressure ulcers.</p> <p>The physician's orders as of 8/21/24 included a low air loss mattress (mattress designed to prevent and treat pressure ulcers). Staff was to verify placement and function of the mattress.</p> <p>Review of the weekly skin checks revealed on 8/31/24, 9/4/24, and 9/8/24 Resident #34 had redness to the coccyx.</p> <p>Review of the nursing progress notes dated 9/1/24 noted, Reddened area with skin breakdown on coccyx area. The nurse noted cleaning with normal saline, applying zinc cream and covered the area with foam dressing.</p> <p>On 9/9/24 at 12:30 p.m., and 2:00 p.m., and on 9/10/24 at 3:40 p.m., Resident #34 was observed lying on her back in bed. A low air loss mattress was not observed on the bed.</p> <p>Review of the Treatment Administration (TAR) for September 2024 revealed the licensed nurses signed the low air loss mattress was in place and functioning:</p> <p>During the day shift on 9/1/24, 9/2/24, 9/4/24, 9/5/24 through 9/10/24.</p> <p>During the evening shift on 9/3/24 through 9/9/24.</p> <p>During the night shift on 9/1/24 through 9/9/24.</p> <p>On 9/10/24 at 3:40 p.m., in an interview the Director of Nursing said he became aware today the low air loss mattress was not on the bed as ordered and the nurses signed the TAR on all three shifts indicating the low air loss mattress was in place and functioning.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 9/10/24 at 3:45 p.m., observation of Resident #34's skin with the Director of Nursing revealed bright redness to the resident's coccyx with no open area. The DON said the nurse who documented the redness to the resident's coccyx did not report the skin issues to the physician.</p> <p>On 9/10/24 the physician issued an order to apply Nystatin-Triamcinolone (used to treat fungal skin infection) topically two times a day to the groin, coccyx, upper and lower back for 14 days.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 21322</p> <p>Based on observation, record review and staff interviews, the facility failed to ensure staff followed safety precautions to prevent avoidable falls and accidents for 1 (Resident #34) of 5 dependent residents observed during transfer with a full body mechanical lift.</p> <p>The findings included:</p> <p>Review of the clinical record for Resident #34 revealed an admitted [DATE].</p> <p>Diagnoses included left Hemiplegia (paralysis of the left side of the body).</p> <p>The Admission Minimum Data Set Assessment with a target date of 8/15/24 noted the resident was dependent on staff for chair to bed transfer (Helper does all of the effort. Resident does none of the effort to complete the activity).</p> <p>The care plan initiated on 8/12/24 noted the resident had an activity of daily living self-care deficit related to a history of cerebrovascular accident, left hemiplegia (paralysis of the left side of the body), impaired mobility and weakness.</p> <p>The interventions noted Resident #34 was totally dependent and required the assistance of two for transfers in and out of chair or bed. The care plan specified to use a (brand name) full body mechanical lift with two person assist.</p> <p>The Certified Nursing Assistant (CNA) Kardex (Provides instructions for safe care) noted to use the (brand name) full body mechanical lift with two person assist.</p> <p>On 9/9/24 at 11:42 a.m., CNA Staff E was observed transferring Resident #34 from the wheelchair to the bed, in her room, using a full body mechanical lift. The CNA operated the lift alone, lifted the resident from the wheelchair, wheeled the resident approximately six feet to the bed, and lowered the resident in the bed.</p> <p>On 9/9/24 at 11:50 a.m., in an interview the CNA Staff E verified he used the full body mechanical lift alone to transfer the resident.</p> <p>He said for safety reasons there should always be two people when using the mechanical lift, in case the resident start to slip or something. He said the facility was short staffed and it would have taken too long, 10 minutes to get help to transfer Resident #34 with the mechanical lift. He said, I don't want to say I'm hardheaded but I'm hardheaded.</p> <p>Review of CNA Staff E's training showed a mechanical lift competency was done on 5/9/24 which specified two caregivers should operate the lift.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/10/24 at 3:56 p.m., in an interview Licensed Practical Nurse Staff B said she supervises the CNAs and helps as needed with transfers with mechanical lifts but does not keep documentation of the supervision.</p> <p>On 9/10/24 at 4:00 p.m., the Director of Nursing said he was aware CNA Staff E used the full body mechanical lift alone and started education on safe use of the full body mechanical lift using two staff members.</p>

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>21322</p> <p>Based on observations, record review and staff interviews, the facility failed to ensure licensed nurses were knowledgeable, and competent in the disinfection of multi-residents shared glucometers in accordance with manufacturer's specifications.</p> <p>On 9/10/24 through 9/11/24, four licensed nurses on two different shifts and all three units of the facility were observed using multi-residents shared glucometers. The licensed nurses failed to disinfect the glucometers between each resident use.</p> <p>This failure placed 17 (Residents #82, #14, #11, #34, #4, #46, #21, #12, #49, #10, #59, #339, #27, #338, #41, #33, #54) of 17 residents requiring blood glucose testing at risk of exposure to blood-borne disease causing microorganisms which could result in serious illness or death of the residents.</p> <p>The facility failure to ensure licensed nurses maintained competency in disinfection of multi-residents shared glucometers to assure residents' safety resulted in the determination of Immediate Jeopardy starting on 9/10/24.</p> <p>The Immediate Jeopardy was removed on 9/12/24 before exit.</p> <p>The findings included:</p> <p>Cross reference F880.</p> <p>Review of the user guide for the blood glucose monitoring system used by the facility read, Healthcare professionals performing blood glucose tests with this system on multiple patients must always wear gloves and should follow infection control policies and procedures approved by the facility. When using this system, always follow the recognized procedures for handling objects that are potentially contaminated with human material.</p> <p>Practice the health and safety policy of your . institution . A drop of blood is required to perform a blood glucose test . All parts of the glucose monitoring system should be considered potentially infectious and are capable of transmitting blood-borne pathogens between patients and healthcare professionals . The meter should be disinfected after use on each patient. This blood glucose monitoring system may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed . A new pair of clean gloves should be worn by the user before testing each patient . Glucose meters used in a clinical setting for testing multiple persons must be cleaned and disinfected between patients . Disinfection Instructions: The meter must be disinfected between each patient uses by wiping it with a [brand name] towelette or EPA (Environmental Protection Agency)-registered disinfecting wipe in between tests . The Disinfection process reduces the risk of transmitting infectious diseases if it performed properly . Allow the surface of the meter to remain wet for the contact time listed on the disinfecting wipe's instructions for use .</p> <p>1. On 9/10/24 at 4:40 p.m., Registered Nurse (RN) Staff A was observed performing a fingerstick to measure blood glucose level for Resident #82.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>RN Staff A retrieved the glucometer from the top drawer of the medication cart. She placed the meter on the resident's over the bed table. RN Staff A did not disinfect the glucometer, she did not wash or sanitize her hands. Staff A did not wear gloves to perform the fingerstick. She obtained a drop of blood from the resident's finger and placed it on the test strip inserted in the glucometer. RN Staff A wiped the blood from the resident's finger with an alcohol wipe without gloves. Staff A left the room, placed the glucometer on the medication cart. She picked up the glucometer, quickly wiped it with an alcohol wipe. She placed the glucometer on the medication cart and said she'll let the meter dry here before using it on another resident. The glucometer was completely dry within six seconds.</p> <p>RN Staff A measured two units of Lispro insulin into a syringe. She went back in Resident #82's room and injected the insulin in the resident's right upper arm without using gloves, washing, or sanitizing her hands.</p> <p>RN Staff A left the room, sanitized her hands with hand sanitizer and said she was going to obtain the blood sugar for Resident #14.</p> <p>On 9/10/24 at 4:58 p.m., RN Staff A took the non-disinfected glucometer she used to check Resident #82's blood sugar to Resident #14's room. She did not wear gloves and got ready to use the glucometer to measure Resident #14's blood sugar.</p> <p>RN Staff A was asked to stop using the glucometer.</p> <p>On 9/10/24 at 5:00 p.m., in an interview RN Staff A verified she did not disinfect the glucometer between residents.</p> <p>She said the process was to wipe the glucometer with an alcohol wipe between use and let it dry completely before using it again for another resident.</p> <p>RN Staff A said she's used the shared glucometer for five residents (Residents #82, #14, #21, #54, and #33).</p> <p>On 9/10/24 at 5:04 p.m., the observation was shared with the Infection Preventionist (IP).</p> <p>RN Staff A was observed describing how she cleaned the glucometer by wiping it with an alcohol wipe to the IP.</p> <p>The IP instructed her to use the [Brand name] Germicidal Alcohol wipes. She instructed RN Staff A to wear gloves, wipe the front, the back and the sides of the glucometer once with the disinfecting wipe and let it dry for one minute. She said to be sure you can even let it dry two minutes.</p> <p>Review of the manufacturer's instruction for disinfecting for the (brand name) Germicidal Alcohol wipes used by the facility read, To disinfect hard, non-porous surfaces, use one or more wipes as necessary, to thoroughly wet the surface to be treated. Treated surface must remain visibly wet for one minute to achieve complete disinfection of all pathogens listed .</p> <p>Pathogens listed included HIV (Human Immunodeficiency Virus), HBV (Hepatitis B Virus), HCV (Hepatitis C Virus), Rhinovirus, Norovirus, Human coronavirus, Respiratory Syncytial Virus.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>RN Staff A donned clean gloves wiped the front, back and sides of the glucometer once and placed it on a paper towel on the cart to dry. RN Staff A did not observe the glucometer to ensure the meter remained wet for one minute to ensure disinfection. The glucometer progressively dried and was completely dry within 45 seconds.</p> <p>The IP watched RN Staff A improperly disinfect the glucometer. She said, It's better and walked away.</p> <p>The IP did not stop RN Staff A from continuing to use the improperly disinfected blood glucose meter.</p> <p>On 9/10/24 at 5:08 p.m., in an interview the IP said she never said it was perfect, she said it was better.</p> <p>On 9/10/24 at approximately 5:10 p.m., the observations and interviews with Staff A and the IP were shared with the Director of Nursing (DON). The DON said he would in-service RN Staff A right away.</p> <p>Review of the Nursing Home Infection Preventionist Training Course certificate for the facility's Infection Preventionist showed she completed the web-based training on 3/1/24.</p> <p>2. On 9/10/24 at 5:28 p.m., RN Staff C was observed standing next to a medication cart. A glucometer, lancet and alcohol wipe were observed on top of the cart.</p> <p>Staff C said she was about to check Resident #10's evening blood sugar as per physician's order to determine if she needed to receive insulin coverage.</p> <p>Staff C sanitized her hands with alcohol, put on a pair of gloves and proceeded into Resident #10's room. She obtained Resident #10's permission to check the blood sugar.</p> <p>Staff C cleaned Resident #10's left middle finger with an alcohol wipe, proceeded to lance Resident #10's left middle finger. She obtained a drop of blood and used the glucometer to measure the resident's blood sugar.</p> <p>On 9/10/24 at 5:35 p.m., RN Staff C discarded the lancet and glucometer strip into the sharp container. She placed the glucometer on top of the medication cart, removed her gloves, and sanitized her hands with rubbing alcohol.</p> <p>On 9/10/24 at 5:38 p.m., in an interview RN Staff C said she had to check Resident #46's evening blood sugar.</p> <p>On 9/10/24 at 5:41 p.m., Staff C was observed gathering the materials needed to check Resident #46's blood sugar. Staff C was observed cleaning the glucometer with an alcohol pad for approximately 15 seconds. The glucometer was visually dry within five seconds after being wiped with the alcohol pad. The nurse gathered the remaining material and proceeded into Resident #46's room.</p> <p>Staff C was stopped from going into Resident #46's room.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 9/10/24 at 5:55 p.m., in an interview RN Staff C said the facility's policy stated they were required to wipe the glucometer for 20 seconds between each resident with an alcohol pad.</p> <p>3. On 9/10/24 at 5:29 p.m., Licensed Practical Nurse (LPN) Staff B was observed preparing to measure Resident #11's blood sugar.</p> <p>LPN Staff B applied gloves, placed the glucometer, an alcohol wipe, and disposable lancet in a small cardboard box. She placed the box on the resident's over the bed table.</p> <p>She obtained a drop of blood from the resident's finger and used the glucometer to measure the resident's blood sugar.</p> <p>LPN Staff B administered insulin coverage to the resident's left lower abdomen.</p> <p>Staff B removed her gloves, placed the glucometer into the cardboard box. She did not disinfect the glucometer and stored it in the top drawer of the medication cart in the cardboard box.</p> <p>LPN Staff B said she was going to use the glucometer to measure Resident #34's blood sugar.</p> <p>On 9/10/24 at 5:39 p.m., LPN Staff B was observed preparing to measure Resident #34's blood sugar.</p> <p>She took the non-disinfected glucometer she used to measure Resident #11's blood sugar from the medication cart, a disposable lancet and alcohol wipe to Resident #34's room and prepared to do the fingerstick.</p> <p>LPN Staff B was stopped from using the glucometer.</p> <p>On 9/10/24 at 5:41 p.m., in an interview LPN Staff B said she was taught to wipe the multi-residents shared glucometer with an alcohol wipe at the beginning of each shift and again at the end of the shift.</p> <p>When asked about disinfecting the glucometer between each resident's use, she said, Oh yes we do that. She verified she did not disinfect the glucometer before attempting to use it on Resident #34. She said, It skipped my mind.</p> <p>She then wiped the non-disinfected glucometer and the box of testing strips with an alcohol wipe. Continuous observation of the meter showed it was completely dry in five seconds.</p> <p>LPN Staff B prepared to use the non-disinfected glucometer to measure Resident #34's blood sugar.</p> <p>LPN Staff B was asked again to stop using the non-disinfected glucometer.</p> <p>When asked to describe the process to disinfect the glucometers, LPN Staff B said, Basically check if the meter is working properly, clean after providing care to the resident, clean the meter with an alcohol wipe and document in the book.</p> <p>On 9/10/24 at 5:53 p.m., in a joint observation with the DON, LPN Staff B was observed wiping the glucometer with an alcohol wipe and said it was the step by step process.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 9/10/24 at approximately 5:55 p.m., the DON verified LPN Staff B did not properly disinfect the glucometer. He said he will in-service her right away.</p> <p>On 9/10/24 at 6:45 p.m., the DON said the nurses were recently educated on the proper disinfection of glucometers.</p> <p>The DON provided a Glucometer Competency checklist and a Blood Glucose/Glucometer Quiz/Competency form used by the facility.</p> <p>Item #17 on the Glucometer Competency checklist read, Cleans and understands proper maintenance of the glucometer per manufacturer.</p> <p>The Blood Glucose/Glucometer Quiz/Competency form consisted in 10 true or false questions.</p> <p>Question 6 read, The glucometer should be cleaned after each use.</p> <p>Question 7 read, It is acceptable to dry the glucometer after using the bleach wipe.</p> <p>The Glucometer Competency checklist and the Blood Glucose/Glucometer Quiz/Competency form did not describe the step by step process with a specified disinfecting wipe to ensure proper disinfection of the glucometers.</p> <p>RN Staff A signed the Blood Glucose/Glucometer Quiz/Competency form upon hire on 4/18/24.</p> <p>RN Staff C signed the Blood Glucose/Glucometer Quiz/Competency form on 5/9/24.</p> <p>4. On 9/11/24 at 6:38 a.m., RN Staff D was observed doing a blood sugar check on Resident #46. Staff D took the glucometer, a lancet, an alcohol wipe in the resident's room. She donned gloves, did the fingerstick, obtained a drop of blood and used the glucometer to measure the resident's blood sugar.</p> <p>RN Staff D doffed the gloves, sanitized her hands and took the glucometer to the medication cart.</p> <p>RN Staff D donned gloves. She used two (brand name) germicidal alcohol wipes from a tub. She wiped the glucometer for 26 seconds with the disinfecting wipes. She placed the glucometer in a plastic cup and set it on the medication cart. Continuous observation from the time Staff D started using the disinfecting wipes showed the glucometer was completely dry at 45 seconds. RN Staff D verified the glucometer was dry at 45 seconds. She verified she did not ensure the glucometer remained wet for the contact time of one minute listed on the disinfecting wipe.</p> <p>Review of the glucometer competencies revealed RN Staff D signed the Glucometer Competency checklist on 7/14/24.</p> <p>On 9/11/24 at 11:45 a.m., in an interview the DON said he began employment at the facility approximately four months ago. He said they were doing training and getting ready for quarterly education. He said infection control and disinfection of the multi-residents shared glucometers were not an area of concern. He said he observed eight nurses properly disinfect the glucometers.</p> <p>(continued on next page)</p>

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 9/11/24 at 1:30 p.m., the DON said the facility did not have a policy for disinfecting glucometers. He said he would contact a sister facility and ask for their policy.</p> <p>On 9/11/24 at 3:20 p.m., the DON provided a poster board with the Glucometer Competency checklist and Cleaning Glucometer instructions taped to it which he said the facility used in a skills fair completed in July 2024.</p> <p>The Cleaning Glucometer instructions read, Wash hands with soap and water.</p> <p>Put on single use gloves.</p> <p>Use an approved bleach germicidal wipe for cleaning the glucometer.</p> <p>Wipe all external areas of the meter including front and back surfaces until visibly clean.</p> <p>Allow the surface of the meter to remain WET at room temperature for the contact time listed on the wipe's directions for use. DO NOT DRY. ALLOW TO AIR DRY.</p> <p>Remove gloves and perform hand hygiene.</p> <p>Photographic evidence obtained.</p> <p>He said the skills fair consisted in multiple stations, including a station to demonstrate proper disinfection of glucometers. The DON said he personally watched the nurses demonstrating proper disinfection of the glucometers.</p> <p>The DON verified the Glucometer Competency skills checklist did not list a specific EPA (Environmental Protection Agency) product. He did not say which product he watched the nurses used during the skills fair to demonstrate competency in glucometer disinfection.</p> <p>On 9/11/24 at 4:00 p.m., the DON provided a Standards and Guidelines: Blood Glucose policy revised 01/2024 that read, Standard: The purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to prevent transmission of bloodborne diseases to residents and employees . General Guidelines. Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses . Steps in the Procedure: Follow manufacture [sic] instructions.</p> <p>On 9/12/24 the facility provided Glucometer Competency checklists showing LPN Staff B had a competency evaluation related to disinfecting the glucometers on 7/2/24 and 7/14/24.</p> <p>After verification of implementation of an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed as of 9/12/24.</p> <p>The immediate actions implemented by the facility and verified by the survey team included:</p> <p>On 9/10/24 Residents #46, #34, and #82 were assessed by a licensed nurse to ensure no adverse effects were noted from the alleged deficient practice. No issues were identified at the time of the assessment.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 9/12/24 the survey team verified through observation of assessment done.</p> <p>On 9/10/24 RN Staff A, LPN Staff B, and RN Staff D were re-educated by the Director of Nursing/Designee on proper disinfecting of the glucometer machine and provided a return demonstration on proper disinfecting of glucometer machine.</p> <p>On 9/12/24 the survey team verified through review of the education and competency for the licensed nurses.</p> <p>Proof the glucometer disinfection competencies for the four licensed nurses (RN Staff A, LPN Staff B, RN Staff C and RN Staff D)</p> <p>On 9/11/24 the survey team verified documentation of competency evaluation for RN Staff A, RN Staff C and RN Staff D.</p> <p>On 9/11/24 the survey team was provided proof that all current licensed nurses had received prior education and completed return demonstration competencies on disinfection of glucometers during orientation or skills fair training.</p> <p>On 9/12/24 the facility provided Glucometer Competency checklists showing LPN Staff B had a competency evaluation related to disinfecting the glucometers on 7/2/24 and 7/14/24.</p> <p>On 9/12/24 the survey team verified through review of education and competency evaluations provided prior to 9/10/24.</p> <p>The facility provided documentation of training starting on 9/11/24 for 14 of 25 licensed nurses.</p> <p>On 9/11/24 current residents who received blood glucose monitoring were assessed by a licensed nurse to ensure no adverse effects were noted from the alleged deficient practice. No issues were identified at the time of the assessment.</p> <p>On 9/12/24 the survey team verified through review of the assessments.</p> <p>On 9/11/24 current licensed nurses were re-educated in person or via phone by the Assistant Director of Nursing/Designee on the process for glucometer disinfection and 100% completion was achieved on 9/12/24.</p> <p>On 9/12/24 the survey team verified through review of the training provided to the licensed nurses.</p> <p>On 9/11/24 the facility initiated training with current licensed nurses on disinfecting glucometers and have completed competencies with return demonstration, on disinfection of glucometer machines. As of 9/12/24 14 of 25 licensed nurses received the training and had the competency evaluation. Those licensed nurses who have not completed competency validation will not be allowed to work until completed.</p> <p>On 9/12/24 the survey team verified through review of the education and competency evaluations.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 9/12/24 all four nurses on duty were interviewed and were able to verbalize the process for disinfecting the glucometers using the selected EPA approved disinfecting wipes.</p> <p>On 9/12/24 the Infection Preventionist was re-educated on proper disinfection of glucometer machine by the Director of Nursing and provided return demonstration on proper disinfection of glucometer machines.</p> <p>On 9/12/24 the survey team verified through review of the education and return demonstration for the Infection Preventionist.</p> <p>On 9/11/24 the facility implemented a new process where each resident requiring blood glucose monitoring will be provided with their own individual glucometer machines which will be stored in plastic containers with lids and their names to identify individual glucometer machine. Process implemented for all current residents receiving blood glucose monitoring on 9/11/24.</p> <p>As of 9/11/24 all current medication carts are equipped with a plastic basket to hold EPA approved disinfection wipes, timers to ensure timeliness of disinfection, instructions on how to disinfect glucometer machines and contact time listed on the container of the disinfectant wipes.</p> <p>On 9/12/24 the survey team verified by observation of all six medication carts and interview with all four nurses on duty.</p> <p>Each resident requiring blood glucose monitoring had an individual glucometer stored in a plastic container with a lid. Each resident's name was labeled with the resident's name.</p> <p>Each cart had a timer to ensure the wet contact time per manufacturer's specification for the disinfecting wipes.</p> <p>Four of four licensed nurses on duty were interviewed and verified they had received training followed by competency evaluation for disinfecting glucometers using the facility's chosen EPA approved disinfecting wipes. All four nurses interviewed were able to describe the step by step process for disinfection of the glucometers and the required contact time for the disinfecting wipes.</p> <p>On 9/12/24 the Medical Director was contacted to review the recommendations for monitoring of the current residents potentially affected by the alleged deficient practice; new orders received for monitoring CBC (Complete Blood Count) with Diff (Differential) once in the morning and then again in 7 days; also monitor vital signs every day for duration of 7 days starting on 9/12/24.</p> <p>On 9/12/24 the survey team verified through review of documentation of Medical Director contact and orders for all 17 current residents requiring blood glucose monitoring.</p> <p>Newly hired nurses will be educated on proper disinfection of glucometers by the Assistant Director of Nursing/Designee and provide return demonstration as part of orientation.</p> <p>On 9/12/24 the survey team verified through review of the process for education of newly hired nurses on proper disinfection of glucometers.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Currently the facility is not utilizing agency licensed nurses; in the event that the facility would need to utilize licensed agency staff, those licensed agency nurses would be educated on proper disinfection of glucometers and provide return demonstration.</p> <p>On 9/12/24 the survey team verified through documented process to educate agency licensed nurses on proper disinfection of glucometers.</p> <p>DON/Designee will conduct audits on five nurses, five times a week for four weeks then three times a week for four weeks then weekly for four weeks to ensure proper disinfection of blood glucose machines is maintained. Findings of the audits will be reviewed weekly in the Quality Assurance Meetings.</p> <p>On 9/12/24 the survey team verified through review of documented plan for audits, and interview with the DON.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>21322</p> <p>Based on observations, record review, and staff interviews, the facility failed to ensure its medication error rate was below 5%. Five nurses, seven residents and 25 opportunities were observed. Three medication errors were identified resulting in a medication error rate of 12%.</p> <p>The findings included:</p> <p>1. On 9/10/24 at 8:37 a.m., Licensed Practical Nurse (LPN) Staff F was observed preparing and administering medications to Resident #36, including 10 different oral medications.</p> <p>Reconciliation of the observation with the physician's orders revealed:</p> <p>MiraLax oral packet 17 grams (laxative), and Fexofenadine 180 milligrams (antihistamine) scheduled to be given at 9:00 a.m., daily were not administered.</p> <p>LPN Staff F placed her initials on the Medication Administration Record (MAR) for 9/10/24 indicating the medications were administered in accordance with the physician's orders.</p> <p>On 9/10/24 at 2:20 p.m., in an interview LPN Staff F verified she did not administer the MiraLax or the Fexofenadine to Resident #36 but signed on the MAR she administered both medications as ordered.</p> <p>2. On 9/10/24 at 4:33 p.m., Registered Nurse (RN) Staff A was observed preparing to administer Fluticasone propionate/salmeterol diskus 500/50 aerosol powder breath activated inhaler to Resident #13 for chronic obstructive pulmonary disease.</p> <p>Staff A handed the inhaler to the resident. Resident #13 took one inhalation orally and gave the inhaler back to the nurse.</p> <p>RN Staff A left the resident's room and placed the inhaler back in the medication cart.</p> <p>Observation of the label on the medication box specified to rinse mouth thoroughly after each use.</p> <p>Photographic evidence obtained.</p> <p>RN Staff A did not instruct the resident to rinse her mouth and not swallow the water after the inhalation.</p> <p>On 9/10/24 at 4:39 p.m., in an interview RN Staff A verified she did not instruct the resident to rinse her mouth in accordance with the manufacturer's specification. RN Staff A said she forgot.</p> <p>Review of the manufacturer's insert for the Fluticasone propionate/salmeterol revealed to advise patients to rinse the mouth with water without swallowing after inhalation to help reduce the risk of thrush (fungal/yeast infection that can grow in the mouth, throat and other parts of the body).</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/12/24 at 12:30 p.m., the medication errors observed were discussed with the Director of Nursing (DON). The DON was informed of the medication error rate of 12%.</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>21322</p> <p>Based on observation, record review and staff interviews the facility failed to maintain an on-going infection prevention and control program by failing to ensure multi-residents shared glucometers (blood glucose meters) were properly disinfected between each resident use to prevent cross contamination and spread of infectious agents to 17 (Residents #82, #14, #11, #34, #4, #46, #21, #12, #49, #10, #59, #339, #27, #338, #41, #33, #54) of 17 residents requiring blood glucose testing.</p> <p>On 9/10/24 through 9/11/24 a total of four licensed nurses on different shifts and units were observed using multi-residents shared glucometers. The nurses failed to disinfect the glucometers between each resident use.</p> <p>The facility's failure to ensure proper disinfection of the glucometers in accordance with manufacturer's specifications placed 17 residents requiring blood glucose testing at risk of exposure to blood-borne disease causing microorganisms which could result in serious illness or death of the residents.</p> <p>This failure resulted in the determination of Immediate Jeopardy starting on 9/10/24.</p> <p>The Immediate Jeopardy was removed on 9/12/24 prior to exit.</p> <p>The findings included:</p> <p>Cross reference F726.</p> <p>Review of the Center for Disease Control Considerations for Blood Glucose Monitoring and Insulin Administration dated August 7, 2024, read, . Blood glucose meters. Whenever possible, assign blood glucose meters to a person and do not share them . If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per the manufacturer's instructions, to prevent the spread of blood and infectious agents . If healthcare providers use blood glucose testing or insulin administration devices on more than one patient, equipment and supplies may become contaminated. Unsafe practices during assisted monitoring of blood glucose and insulin administration contribute to the spread of hepatitis B virus, hepatitis C virus, Human Immunodeficiency Virus (HIV), and other infections.</p> <p>Unsafe practices include:</p> <ul style="list-style-type: none"> <li>. Using a blood glucose meter for more than one person without cleaning and disinfecting it in between uses</li> <li>. Failing to change gloves and perform hand hygiene between fingerstick procedures.</li> </ul> <p><a href="https://www.cdc.gov/injection-safety/hcp/infection-control/?CDC_AAref_Val=https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html#cdc_infection_control_impleme-recommend-practices-in-healthcare-settings">https://www.cdc.gov/injection-safety/hcp/infection-control/?CDC_AAref_Val=https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html#cdc_infection_control_impleme-recommend-practices-in-healthcare-settings</a></p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of the user guide for the blood glucose monitoring system used by the facility read, Healthcare professionals performing blood glucose tests with this system on multiple patients must always wear gloves and should follow infection control policies and procedures approved by the facility. When using this system, always follow the recognized procedures for handling objects that are potentially contaminated with human material.</p> <p>Practice the health and safety policy of your . institution . A drop of blood is required to perform a blood glucose test . All parts of the glucose monitoring system should be considered potentially infectious and are capable of transmitting blood-borne pathogens between patients and healthcare professionals . The meter should be disinfected after use on each patient. This blood glucose monitoring system may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed . A new pair of clean gloves should be worn by the user before testing each patient . Glucose meters used in a clinical setting for testing multiple persons must be cleaned and disinfected between patients . Disinfection Instructions: The meter must be disinfected between each patient uses by wiping it with a [brand name] towelette or EPA (Environmental Protection Agency)-registered disinfecting wipe in between tests . The Disinfection process reduces the risk of transmitting infectious diseases if it is performed properly . allow the surface of the meter to remain wet for the contact time listed on the disinfecting wipe's instructions for use .</p> <p>1. On 9/10/24 at 4:40 p.m., Registered Nurse (RN) Staff A was observed performing a fingerstick to measure blood glucose level for Resident #82.</p> <p>RN Staff A retrieved the glucometer from the top drawer of the medication cart. She placed the meter on the resident's over the bed table. RN Staff A did not disinfect the glucometer. She did not wash or sanitize her hands. RN Staff A did not follow infection prevention practice. She did not wear gloves to perform the fingerstick. She obtained a drop of blood from the resident's finger and placed it on the test strip inserted in the glucometer. RN Staff A wiped the blood from the resident's finger with an alcohol wipe without gloves. Staff A left the room, placed the glucometer on the medication cart. She picked up the glucometer, quickly wiped it with an alcohol wipe. She placed the glucometer on the medication cart and said she'll let the meter dry here before using it on another resident. The glucometer was completely dry within 6 seconds.</p> <p>RN Staff A measured two units of Lispro insulin into a syringe. She went back in Resident #82's room and injected the insulin in the resident's right upper arm without washing, sanitizing her hands or using gloves.</p> <p>RN Staff A left the room, sanitized her hands with hand sanitizer and said she was going to obtain the blood sugar for Resident #14.</p> <p>On 9/10/24 at 4:58 p.m., RN Staff A took the non-disinfected glucometer used to check Resident #82's blood sugar to Resident #14's room. She did not wear gloves and got ready to use the glucometer to measure Resident #14's blood sugar.</p> <p>RN Staff A was asked to stop using the glucometer.</p> <p>On 9/10/24 at 5:00 p.m., in an interview RN Staff A verified she did not disinfect the glucometer between residents. Staff A verified she did not follow standard precautions and did not wear gloves to wipe Resident #82's blood from the fingerstick.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>She said the process was to wipe the glucometer with an alcohol wipe between use and let it dry completely before using it again for another resident.</p> <p>RN Staff A said she's used the shared glucometer on five residents (Residents #82, #14, #21, #54, and #33).</p> <p>On 9/10/24 at 5:04 p.m., the observation was shared with the Infection Preventionist (IP).</p> <p>RN Staff A was observed describing how she cleaned the glucometer by wiping it with an alcohol wipe to the IP.</p> <p>The IP instructed her to use the [Brand name] Germicidal Alcohol wipes. She instructed RN Staff A to wear gloves, wipe the front, the back and the sides of the glucometer once with the disinfecting wipe and let it dry for one minute. She said to be sure you can even let it dry two minutes.</p> <p>Review of the manufacturer's instruction for disinfecting for the (brand name) Germicidal Alcohol wipes used by the facility read, To disinfect hard, non-porous surfaces, use one or more wipes as necessary, to thoroughly wet the surface to be treated. Treated surface must remain visibly wet for one minute to achieve complete disinfection of all pathogens listed .</p> <p>Pathogens listed included HIV (Human Immunodeficiency Virus), HBV (Hepatitis B Virus), HCV (Hepatitis C Virus), Rhinovirus, Norovirus, Human coronavirus, Respiratory Syncytial Virus.</p> <p>RN Staff A donned clean gloves wiped the front, back and sides of the glucometer once and placed it on a paper towel on the cart to dry. RN Staff A did not observe the glucometer to ensure the meter remained wet for one minute to ensure disinfection. The glucometer was observed to progressively dry. The glucometer was completely dry be within 45 seconds.</p> <p>The IP watched RN Staff A improperly disinfect the glucometer. She said, It's better and walked away.</p> <p>The IP did not stop RN Staff A from continuing to use the improperly disinfected blood glucose meter.</p> <p>On 9/10/24 at 5:08 p.m., in an interview the IP said she never said it was perfect, she said it was better.</p> <p>On 9/10/24 at approximately 5:10 p.m., the observations and interviews with Staff A and the IP were shared with the Director of Nursing (DON). The DON said he would in-service RN Staff A right away.</p> <p>Review of the Medication Administration Record (MAR) for September 2024 revealed Residents #82, #14, #21, #54 and #33's resided on the same hallway and on 9/10/24 at 11:30 a.m., RN Staff A monitored the blood glucose for all five residents.</p> <p>2. On 9/10/24 at 5:28 p.m., RN Staff C was observed standing next to a medication cart. A glucometer, lancet and alcohol wipe were observed on top of the cart.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Staff C said she was about to check Resident #10's evening blood sugar as per physician's order to determine if she needed to receive insulin coverage.</p> <p>Staff C sanitized her hands with alcohol, put on a pair of gloves and proceeded into Resident #10's room. She obtained Resident #10's permission to check the blood sugar.</p> <p>Staff C cleaned Resident #10's left middle finger with an alcohol wipe, proceeded to lance Resident #10's left middle finger. She obtained a drop of blood and used the glucometer to measure the resident's blood sugar.</p> <p>On 9/10/24 at 5:35 p.m., RN Staff C discarded the lancet and glucometer strip into the sharp container. She placed the glucometer on top of the medication cart, removed her gloves, and sanitized her hands with rubbing alcohol.</p> <p>On 9/10/24 at 5:38 p.m., in an interview RN Staff C said she had to check Resident #46's evening blood sugar.</p> <p>On 9/10/24 at 5:41 p.m., Staff C was observed gathering the materials needed to check Resident #46's blood sugar. Staff C was observed cleaning the glucometer with an alcohol pad for approximately 15 seconds. The glucometer was visually dry within five seconds after being wiped with the alcohol pad. The nurse gathered the remaining material and proceeded into Resident #46's room.</p> <p>Staff C was stopped from going into Resident #46's room.</p> <p>On 9/10/24 at 5:55 p.m., in an interview RN Staff C said the facility's policy stated they were required to wipe the glucometer for 20 seconds between each resident with an alcohol pad.</p> <p>3. On 9/10/24 at 5:29 p.m., Licensed Practical Nurse (LPN) Staff B was observed preparing to measure Resident #11's blood sugar.</p> <p>LPN Staff B donned gloves, placed the glucometer, an alcohol wipe, and disposable lancet in a small cardboard box and placed the box on the resident's over the bed table.</p> <p>She obtained a drop of blood from the resident's finger and used the glucometer to measure the resident's blood sugar.</p> <p>LPN Staff B administered insulin coverage to the resident's left lower abdomen.</p> <p>Staff B removed her gloves, placed the glucometer into the cardboard box. She did not disinfect the glucometer and stored it in the top drawer of the medication cart.</p> <p>LPN Staff B said she was going to use the glucometer next to measure Resident #34's blood sugar.</p> <p>On 9/10/24 at 5:39 p.m., LPN Staff B was observed preparing to measure Resident #34's blood sugar.</p> <p>She took the non-disinfected glucometer used to measure Resident #11's blood sugar from the medication cart, a disposable lancet and alcohol wipe to Resident #34's room and prepared to do the fingerstick.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Crescent Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5401 Sawyer Rd Sarasota, FL 34233	

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>LPN Staff B was stopped from using the glucometer.</p> <p>On 9/10/24 at 5:41 p.m., in an interview LPN Staff B said she was taught to wipe the multi-residents shared glucometer with an alcohol wipe at the beginning of each shift and again at the end of the shift.</p> <p>When asked about disinfecting the glucometer between each resident's use, she said, Oh yes we do that. She verified she did not disinfect the glucometer before attempting to use it on Resident #34.</p> <p>LPN Staff B said, It skipped my mind.</p> <p>She wiped the non-disinfected glucometer and the box of testing strips with an alcohol wipe. Continuous observation of the meter showed it was completely dry in five seconds. LPN Staff B walked back in Resident #34's room.</p> <p>LPN Staff B was asked again to stop using the non-disinfected glucometer.</p> <p>When asked to describe the process to disinfect the blood glucose meters, LPN Staff B said, Basically check if the meter is working properly, clean after providing care to the resident, clean the meter with an alcohol wipe and document in the book.</p> <p>On 9/10/24 at 5:53 p.m., in a joint observation with the DON, LPN Staff B was observed wiping the glucometer with an alcohol wipe and said it was the step by step process.</p> <p>On 9/10/24 at approximately 5:55 p.m., the DON verified LPN Staff B did not properly disinfect the glucometer.</p> <p>On 9/10/24 at 6:45 p.m., the DON said the nurses were recently educated on the proper disinfection of glucometers.</p> <p>The DON provided a list of 24 licensed nurses who he said were currently employed at the facility.</p> <p>The DON provided a glucometer competency checklist for 15 of the 24 Licensed Nurses. The facilitator listed on the competency checklist was the Director of Nursing.</p> <p>Seven of the 24 nurses had a competency in August 2024. The checklist included: Item 17, Cleans and understands proper maintenance of glucometer per manufacturer.</p> <p>Eight nurses had a Blood Glucose/ Quiz/Competency form which consisted of 10 true or false questions. Question 6 read, The glucometer should be cleaned after each use.</p> <p>On 9/10/24 at 7:00 p.m., the DON said he did not have a policy for disinfecting glucometers. He said he contacted the Regional Nurse and was awaiting.</p> <p>4. On 9/11/24 at 6:38 a.m., RN Staff D was observed doing a blood sugar check on Resident #46. Staff D took the glucometer, a lancet, an alcohol wipe in the resident's room. She donned gloves, did the fingerstick, obtained a drop of blood and used the glucometer to measure the resident's blood sugar.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>RN Staff D doffed the gloves, sanitized her hands and took the glucometer to the medication cart.</p> <p>RN Staff D donned gloves. She used two (brand name) germicidal alcohol wipes from a tub. She wiped the glucometer for 26 seconds with the disinfecting wipes. She placed the glucometer in a plastic cup and set it on the medication cart. Continuous observation from the time Staff D started using the disinfecting wipes showed the glucometer was completely dry at 45 seconds. RN Staff D verified the glucometer was dry at 45 seconds. She verified she did not ensure the glucometer remained wet for the contact time of one minute listed on the disinfecting wipe.</p> <p>On 9/11/24 at 7:00 a.m., 10:30 a.m., and 12:15 p.m., the DON was asked but did not provide the facility's policy and procedure for disinfecting blood glucose meters.</p> <p>On 9/11/24 at 1:30 p.m., the DON said the facility did not have a policy for disinfecting glucometers. He said he would contact a sister facility and ask for their policy.</p> <p>On 9/11/24 at 3:34 p.m., in an interview the Medical Director said the use of 30 seconds to one minute contact time of cleaning the glucometer with alcohol 70% was acceptable and caused minimal risk to the patients. He said the real risk was for HIV and HBV (Hepatitis B Virus). He said if someone used the toothbrush of a person with gingivitis and infected with HBV even minimal amount of blood can transmit HBV. When asked about the nurse not using gloves to wipe blood from a resident's finger, the Medical Director said exposure to the nurse was dependent on the nurse catching blood on her hands. She wiped the blood with a damp alcohol pad so the blood got in the alcohol pad. He was not too worried about cross contamination. The Medical Director said they were now teaching the nurses the standards.</p> <p>On 9/11/24 at 4:00 p.m., the DON provided a Standards and Guidelines: Blood Glucose revised 01/2024 that read, Standard: The purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to prevent transmission of bloodborne diseases to residents and employees . General Guidelines. Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses . Steps in the Procedure: Follow manufacture [sic] instructions.</p> <p>After verification of implementation of an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed as of 9/12/24.</p> <p>The immediate actions implemented by the facility and verified by the survey team included:</p> <p>On 9/10/24 Residents #46, #34, and #82 were assessed by a licensed nurse to ensure no adverse effects were noted from the alleged deficient practice. No issues were identified at the time of the assessment.</p> <p>On 9/12/24 the survey team verified through observation of assessment done.</p> <p>On 9/10/24 RN Staff A, LPN Staff B, and RN Staff D were re-educated by the Director of Nursing/Designee on proper disinfecting of the glucometer machine and provided a return demonstration on proper disinfecting of glucometer machine.</p> <p>On 9/12/24 the survey team verified through review of the education and competency for the licensed nurses.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 9/11/24 an Ad Hoc (unplanned) Quality Assurance Meeting was held with the facility Medical Director in attendance. The following team members were also in attendance: Facility Administrator, Regional Nurse Consultant, Director of Nursing, Unit Manager, Human Resources Director, AIT (Applied Information Technology), and Assistant Director of Nursing. The Ad Hoc QAPI (Quality Assurance and Performance Improvement) committee approved the recommendations. The Ad Hoc QA included a Performance Improvement Plan developed and initiated based upon Root Cause Analysis.</p> <p>On 9/11/24 the survey team was provided proof that all current licensed nurses had received prior education and completed return demonstration competencies on disinfection of glucometers during orientation or skills fair training.</p> <p>On 9/12/24 the facility provided the survey team with documentation of prior education and glucometer and competencies.</p> <p>On 9/11/24 current residents who received blood glucose monitoring were assessed by a licensed nurse to ensure no adverse effects were noted for the alleged deficient practice. No issues were identified at the time of assessment.</p> <p>On 9/12/24 the survey team verified through review of the assessment of the current residents receiving blood glucose monitoring.</p> <p>On 9/11/24 current licensed nurses were re-educated in person or via phone by the Assistant Director of Nursing/Designee on the process for glucometer disinfection and 100% completion was achieved on 9/12/24.</p> <p>On 9/12/24 the survey team verified through review of the education provided to all current licensed nurses employed at the facility.</p> <p>On 9/11/24 the facility initiated training with current licensed nurses on disinfecting glucometers and have completed competencies with return demonstration, on disinfection of glucometer machines. As of 9/12/24 14 of 25 licensed nurses completed the training and competencies on disinfecting glucometers.</p> <p>On 9/12/24 the survey team verified through review of the training provided to 14 licensed nurses.</p> <p>On 9/11/24 the facility implemented a new process where each resident requiring blood glucose monitoring will be provided with their own individual glucometer machines which will be stored in plastic containers with lids and their names to identify individual glucometer machine. Process implemented for all current residents receiving blood glucose monitoring on 9/11/24.</p> <p>On 9/11/24 the facility reviewed the new process changes of individualized glucometers and the implementation of baskets on the nurses med carts to hold the sanitizer, timer, instructions for disinfections and contact time marked on the disinfectant wipe; Medical Director was in agreement with the new process.</p> <p>On 9/12/24 the survey team verified by observation of all six medication carts and interview with all four nurses on duty.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Each resident requiring blood glucose monitoring had an individual glucometer stored in a plastic container with a lid. Each resident's name was labeled with the resident's name.</p> <p>Each cart had a timer to ensure the wet contact time per manufacturer's specification for the disinfecting wipes.</p> <p>On 9/12/24 four of four licensed nurses on duty were interviewed. All four licensed nurses were able to verbalize the process for proper disinfection of glucometers and verified they had received training followed by competency evaluation for disinfecting glucometers using the facility's chosen EPA approved disinfecting wipes. All four nurses interviewed were able to describe the step by step process for disinfection of the glucometers and the required contact time for the disinfecting wipes.</p> <p>On 9/12/24 the Medical Director was contacted to review the recommendations for monitoring of the current residents potentially affected by the alleged deficient practice; new orders received for monitoring CBC (Complete Blood Count) with Diff (Differential) once in the morning and then again in 7 days; also monitor vital signs every day for duration of 7 days starting on 9/12/24.</p> <p>On 9/12/24 the survey team verified through review of documentation of Medical Director contact and orders for all 17 current residents requiring blood glucose monitoring.</p> <p>On 9/12/24 the Infection Preventionist was re-educated on proper disinfection of glucometer machine by the Director of Nursing and provided return demonstration on proper disinfection of glucometer machines.</p> <p>On 9/12/24 the survey team verified through review of the training and return demonstration documentation for the Infection Preventionist.</p> <p>Newly hired nurses will be educated on proper disinfection of glucometers by the Assistant Director of Nursing/Designee and provide return demonstration as part of orientation.</p> <p>On 9/12/24 the survey team verified through review of the process for education of newly hired nurses on proper disinfection of glucometers.</p> <p>Currently the facility is not utilizing agency licensed nurses; in the event that the facility would need to utilize licensed agency staff, those licensed agency nurses would be educated on proper disinfection of glucometers and provide return demonstration.</p> <p>On 9/12/24 the survey team verified through documented process to educate agency licensed nurses on proper disinfection of glucometers.</p> <p>DON/Designee will conduct audits on five nurses, five times a week for four weeks then three times a week for four weeks then weekly for four weeks to ensure proper disinfection of blood glucose machines is maintained. Findings of the audits will be reviewed weekly in the Quality Assurance Meetings.</p> <p>On 9/12/24 the survey team verified through review of documented plan for audits.</p>		