STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E050	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buchanan County Health Center	1600 First Street East Independence, IA 50644

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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, clinical record review, manufacturer's use guide, policy review and staff interview the facility failed to use one blood glucose meter per resident (a device used to monitor blood sugar levels) and properly disinfect shared blood glucose meters according to the Center for Disease Control and Prevention (CDC) and Food and Drug Administration (FDA) guidelines for 5 of 5 residents reviewed (Resident #8, #9, #11, #14 and #34). The facility identified a census of 35 residents.Findings include:1.Observation on 3/17/26 during the morning medication pass from 7:30 AM to 9:00 AM revealed Staff A, Registered Nurse (RN) performed a blood sugar for Resident #34. Staff A returned to the medication cart, wiped the blood glucose machine with an alcohol prep pad, and placed in the medication cart. Staff A was observed on the 400-hallway medication cart. 2.During an interview on 3/18/26 at 8:04 AM, Staff B, RN reported she was a newer nurse to the facility. The nurses had one blood glucose meter in each medication cart that they used for multiple residents. They used an alcohol prep pad to clean the meter after each resident blood sugar. Staff B stated Resident #34 was the only resident that used the meter on the 400 medication cart and Resident's #8 and #11 used the meter on the 300 medication cart. 3.Resident #8's 1/13/26 Minimum Data Set (MDS) Assessment showed a Brief Interview for Mental Status (BIMS) Score of 15 out of 15 indicating intact cognition. The MDS listed a diagnosis of diabetes mellitus and documented Resident #8 received insulin injections 7 days a week. The MDS listed Resident #8 resided in a room on the 300 hallway. The resident's Care Plan focus area dated 6/07/24 for Altered Endocrine Status related to Type II Diabetes Mellitus (DM) directed to check the blood sugars as ordered by the physician. An Order Review History Report signed by the Provider on 2/16/26 documented to perform blood sugar checks daily at different times. The March 2026 Electronic Medication Administration Record (EMAR) showed Resident #8 was due for blood sugar on 3/19/26 before lunch. Observation on 3/19/26 at 11:01 AM revealed Staff C, RN reported she planned to completed Resident #8's blood sugar. Staff C pushed the medication cart down the 300-hallway outside of Resident #8's room. Staff C pulled a clean barrier paper out of a box, removed the blood glucose machine, alcohol prep pad, lancet and 2 x 2 inch gauze from the medication cart onto the barrier paper. Staff C removed the cap to the lancet and touched the garbage lid to throw away the cap, then proceeded to apply gloves without performing hand hygiene and touched the bottle of blood sugar strips. Staff C opened and placed a strip into the machine, then locked the cart and proceeded into Resident #8's room. Staff C completed the blood sugar, came back out of the room, and placed the barrier on top of the medication cart. Staff C proceeded to clean the blood glucose machine with a 70% alcohol prep pad rubbing the alcohol prep pad over the front, back and bottom of the meter where the strip had been for a few seconds and then placed the meter back in the medication cart.During an interview on 3/19/26 at 11:12 AM, Staff C explained they had always cleaned the blood glucose meters with alcohol, that was just what they had done. The night shift also cleaned the meters at night. Staff A voiced the meter was a shared meter used for Resident #8, #11 and #14.During an interview on 3/19/26 at 11:20 AM, Staff B reported the nurses cleaned the blood glucose meters with the alcohol prep pads and referred to the 70% alcohol prep pad. She reported she had misspoke the other day, the nurses used the same blood glucose meter (in the 400 medication cart) to check blood sugars for Residents #9 and #34 and the same meter (in the 300 medication cart) (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E050	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buchanan County Health Center	1600 First Street East Independence, IA 50644

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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to check blood sugars on the 300 hallway for Resident #8, #11 and #14. On 3/19/26 at 11:29 AM, the Nurse Manager reported both blood glucose meters on the 300 and 400 hallway medication carts were the same brand. During an interview on 3/19/26 at 11:50 AM, the Nurse Manager reported the Executive Director of Senior Operations was on her way to a big box retail store to purchase all new blood glucose meters so that each resident would have their own blood glucose meter and the nurses would clean the meters with disinfection wipes. She voiced they had just discovered the disinfection issue when asked for additional information on the blood glucose meters. The Nurse Manager confirmed the blood glucose meters were being shared for Residents #8, #9, #11, #14 and #34 with only alcohol being used for cleaning. A 3/19/26 12:15 PM review of Resident's #8, #11, and #14 January, February and March 2026 EMAR's showed nursing performed the blood sugars checks as ordered from 1/1/26 to 3/19/26 for DM. Resident #9's January, February and March 2026 EMARs show he received blood sugar checks from 1/07/26-2/09/25 and 2/12/26 - 3/19/26. Resident #34's March 2026 EMAR showed she had blood sugar checks as ordered from 3/04/26 - 3/12/26 and 3/15/26 - 3/19/26 for DM.The Cleaning and Disinfecting Policy revised 6/25/25 documented the environment of the nursing home would be cleaned and/or disinfected on a routine basis to assist with infection prevention and control. The Policy directed clinical staff were responsible to clean and disinfect reusable resident care items including glucometers. The manufacturer's instructions would be followed regarding all cleaning and disinfecting. The Policy failed to identify following established standards for disinfection per the Center for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA). The Brand Specific Blood Glucose Monitoring System User Guide, under Intended Use documented the Brand Specific blood glucose monitoring system was intended for self-testing by persons with DM and health care professionals for use on a single patient. The Meter was for single patient use only. Under Potential Biohazard the Guide directed all parts of the kit were considered biohazardous and could potentially transmit infectious diseases, even after performing cleaning and disinfection. All products that came in contact with human blood should be handled as if capable of transmitting infectious diseases. The Guide, under Cleaning and Disinfection, directed to clean the meter once a week with a bleach wipe as a single patient use machine. The Guide defined Cleaning as the removal of visible dirt and debris that did not reduce the risk of transmission of infectious diseases. The Guide revealed Disinfecting , if performed properly, reduced the risk of transmitting infectious diseases. The CDC Injection Safety 8/7/24 Considerations for Blood Glucose Monitoring and Insulin Administration for Health Care Providers under Recommended Practices in Healthcare Settings, Blood Glucose Meters directed:a. Whenever possible, assign blood glucose meters to a person and do not share them.b. Dedicated meters should be cleaned and disinfected per the manufacturer's instructions and, at a minimum, anytime the device is reassigned to a different person. Dedicated meters should be stored in a manner that prevents cross-contamination and inadvertent use for the wrong patient. c. 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 the manufacturer does not specify how the device should be cleaned and disinfected, it should not be shared.The FDA's Letter to Manufacturers of Blood Glucose Monitoring Systems Listed With the FDA excerpt from the guidance read: the disinfection solvent should be effective against HIV (Human Immunodeficiency virus, a virus that attacks the body's immune system), Hepatitis C (a contagious liver disease contracted through infected blood), and Hepatitis B (a virus contracted through infected blood or body fluids that leads to liver damage). Outbreak episodes have been largely due to transmission of Hepatitis B and C viruses. However, of the two, Hepatitis B virus is the most difficult to kill. Please note that 70% ethanol solutions are not effective against viral bloodborne pathogens.