

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235174	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER Marshall Nursing and Rehabilitation Community		STREET ADDRESS, CITY, STATE, ZIP CODE 575 N Madison St Marshall, MI 49068	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>49103</p> <p>This citation pertains to intake MI00149290</p> <p>Based on observation and interview the facility failed to maintain documentation to indicate glucometer calibration was being performed potentially affecting all residents (17) who were diagnosed with diabetes with ordered monitoring resulting in the potential for inaccurate blood glucose readings and incorrect treatment.</p> <p>Findings include:</p> <p>On 2/11/25 at 1:09 PM Licensed Practical Nurse (LPN) C was interviewed regarding the process of blood glucose testing. LPN C was asked how she knows a machine is reading results accurately. LPN C responded by saying the glucometer is quality control tested by night shift every 24 hours.</p> <p>On 2/12/25 at 8:55 AM the glucometer calibration logbook was requested and the Assistant Director of Nursing (ADON) F searched for the book.</p> <p>On 2/12/25 at 9:05 AM the Director of Nursing (DON) B and Regional Nurse (RN) G were observed searching for the glucometer calibration logbook at the nurse's station, looking through the medication cart, the cupboards, the files. The logbook was not found. At the second nurse's station at 9:10 AM the logbook was searched for and not found.</p> <p>On 2/12/25 at 10:36 AM the RN G confirmed the logbook was not found and said, We don't have it. It should be a book that is kept available for blood glucometer monitoring. RN G added that this book should be kept reflecting the ongoing (every 24 hour) calibration - testing functioning of the glucometer to assure accuracy. The DON B and RN G also said the testing and book were going to be set up immediately and that a logbook would be kept on each unit for easy access and reference for all nurses on all shifts.</p> <p>According to an article published online by The Mayo Clinic titled Blood Glucose Monitors: What Factors Affect Accuracy dated December 15, 2023, states in part, that blood glucose monitor quality control tests should be done regularly and that following quality control tests can assure you that your meter is working properly.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The glucometer model used by the facility is the Assure Platinum. On the company website there is a copy of the manufacturer's manual which includes a template as an example for a Quality Control Record which has spaces for entry of date, station/shift, operator's initials, test strip lot and expiration date, control range, control result for level 1 Normal Level Control Range, and lot number, expiration date, control range, control result for level 2 High Level Control Range, and Corrective Action (yes, no).</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49103</p> <p>Based on observation, interview and record review the facility failed to maintain disinfection for glucometer's (blood glucose testing devices) affecting residents (R4, R5, R8, and R9) of 4 residents reviewed resulting in the potential for bacterial growth and transmission of pathogens.</p> <p>Findings include:</p> <p>On 2/11/25 at 11:45 AM during medication pass Licensed Practical Nurse (LPN) C was observed performing point-of-care (in resident room) blood glucose testing for R9 using a glucometer. LPN C placed the glucometer on the table without placing a barrier. LPN C was observed after blood glucose testing picking the glucometer up with a gloved hand and carrying it to the medication cart. No disinfection of the glucometer was done prior to leaving the room. LPN C then placed the glucometer on top of the medication cart, removed the gloves she was wearing, disposed of the gloves, and did not follow with sanitization of hands. Disinfection of the glucometer was also not performed.</p> <p>On 2/11/25 at 11:59 AM LPN C picked up the glucometer and walked to the dining table (in the common dining area) of R4 in preparation for glucose testing. LPN C had not sanitized the glucometer and did not place a barrier on the table. The blood glucose test was performed for R4 and after testing the glucometer was not disinfected. LPN C returned to the medication cart and placed the glucometer inside the drawer of the medication cart.</p> <p>On 2/11/25 at 12:25 AM LPN C had gone to another section of the unit and walked to a separate medication cart. After removing a glucometer from the drawer, she performed point-of-care blood glucose testing for R5. The glucometer was not disinfected prior to the testing nor was disinfection performed after the test.</p> <p>On 2/11/25 at 12:56 PM LPN C performed point-of-care blood glucose testing at bedside for R8. No barrier was used. After glucose testing the glucometer was placed by LPN C on top of a stack of clean washcloths as LPN C assisted R8 with an aerosol treatment. LPN C then exited the room carrying the glucometer in a bare hand. No disinfection of the glucometer had been performed and no hand sanitation had been performed. Once back at the cart the glucometer was placed on the cart and LPN C sanitized her hands.</p> <p>On 2/11/25 review of the EMR revealed that R4, R5, R8, and R9 each had a medical diagnosis of Diabetes Mellitus and physician orders for scheduled blood glucose testing.</p> <p>On 2/11/25 at 1:09 PM LPN C was interviewed and asked about the process of blood glucose testing and care of the glucometer. LPN C described the process stating, It should be wiped down with a purple wipe (germicidal disposable wipes) in between uses. LPN C added that supplies of purple wipes were not always readily available to staff. When asked if LPN C regularly requests the germicidal wipes she said, not every day. When asked if on this day (2/11/25) LPN C had requested the germicidal wipes prior to testing LPN C responded, No, I didn't. It's been kind of hectic and time consuming to find someone who can get them. When asked what the risk is of not using the disinfecting wipes LPN C responded basically infection control.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/12/25 at 10:50 AM during interview with the Director of Nursing (DON) B who was also an Infection Preventionist (IP) in training and the Regional Nurse (RN) G who was IP certified (and regularly at the facility 3 days per week) the process of blood glucose testing and care of the glucometer was discussed. The DON B stated, The process for disinfection should be a process of glucose monitoring including hand hygiene, correct resident, gloves, and you want to make sure the glucometer is disinfected. RN G followed up by stating you follow the directions for purple Sani wipes and the contact time should be two minutes.</p> <p>The DON and RN G also talked about training nurses receive on hire on blood glucose testing and annual competencies which are done. The process LPN C used during and after blood glucose testing on 2/11/25 was reviewed and discussed and identified by the DON B and RN G as incorrect and as posing an infection control risk. When asked about audits on glucometer testing the DON B and RN G said audits should be done monthly to confirm that the procedure is being followed correctly and said the audit forms were not readily available but would be found if possible. The surveyor also requested all glucometer testing education forms for all staff who were performing point-of-care blood glucose testing.</p> <p>On 2/12/25 during review of the electronic medical record (EMR) it was determined that of the 17 residents for whom blood glucose testing was ordered none had a blood-borne pathogen diagnosis.</p> <p>On 2/12/25 at approximately 1:00 PM during interview with Licensed Practical Nurse (LPN) D the process of blood glucose monitoring was discussed. LPN D said she looks resident's Medication Administration Record (MAR) up as step one, I gather everything; wash everything down; I sanitize hands and wear gloves. I disinfect it (glucometer) with purple wipes before I go in. And then I have my supplies. Depending on if it is sliding scale, I take blood glucose and get the insulin. LPN D then said once the testing has been completed the glucometer is disinfected again.</p> <p>Prior to exit conference RN G informed the surveyor that audit forms had not been found. Also, prior to exit conference 3 Competency Checklist forms were submitted by the facility reflecting blood glucose testing (equipment cleaning) education for LPNs including one for LPN C dated 9/17/24. No other forms were located prior to exit conference for the remaining staff members who perform blood glucose testing. The facility had 6 LPNs and 7 Registered Nurses (RNs) on the employee list which included the Director of Nursing and Assistant Director of Nursing.</p> <p>The blood glucose monitoring device (glucometer) used by the facility was Assure Platinum. The facility submitted the manufacture's manual which listed the Super Sani-Cloth Germicidal wipes as one of the recommended products to be used for the glucometer. The Guidelines for Cleaning and Disinfecting the Assure Platinum Meter instructions state in part, To minimize the risk of transmitting blood-borne pathogens, the cleaning and disinfecting procedure should be performed as recommended. The manual instructions also state in part, The meter should be cleaned and disinfected after use on each patient.</p> <p>According to an article published in 2013 by Infection Control & Hospital Epidemiology outbreaks of Hepatitis B were reviewed and reported on. The article states in part, Acute hepatitis B virus (HBV) infections have been reported in long-term care facilities (LTCFs) primarily associated with infection control breaks during assisted blood glucose monitoring.</p> <p>(continued on next page)</p>		

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