STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115630	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOLKSTON PARK CARE AND REHABILITATION CENTER	36261 NORTH OKEFENOKEE DRIVE FOLKSTON, GA 31537

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** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, review of facility policies titled, Infection Prevention and Control Program, Cleaning of Equipment, and review of the Medline Evencare G3 Blood Glucose Monitoring System User's Guide and Manufacturer's User Guide, the facility failed to disinfect a glucometer (a device used to measure the glucose in the blood) before completing a finger stick blood sugar (FSBS) for one of 16 residents (R#4). Findings include: Review of the facility's policy titled, Infection Prevention and Control Program, dated June 2016, revealed the facility strived to prevent the transmission of infections and communicable diseases, development of nosocomial infection, and effectively treat and manage nosocomial and community acquired infections. The program was developed based on nationally recognized organizational standards and procedures. The infection prevention and control process were directed at lowering risk and improving trends and rates of epidemiologically significant infections. The process included prevention by using standard precautions, transmission-based precautions, personnel health, engineering and work practice controls and exposure control plans for [MEDICAL CONDITION] and blood borne pathogens. Review of the facility's infection control policy titled, Cleaning of Equipment, undated, revealed all glucometers must be cleaned and disinfected after each resident use, in between resident use, and when in contact with blood or body spills with Sani-cloths (Super Sani-cloth 1 minute purple top). Review of the Medline Evencare G3 Blood Glucose Monitoring System User's Guide, revised 12/2018, revealed the Evencare G3 meter should be cleaned and disinfected between each patient and the following products were approved for cleaning and disinfecting the meter: Dispatch Hospital Cleaner Disinfectant Towels with Bleach (EPA Registration Number -8), Medline Micro-Kill? (Trademark) Disinfecting, Deodorizing, Cleaning Wipes with Alcohol (EPA Registration Number -10), Clorox Healthcare Bleach Germicidal and Disinfectant Wipes (EPA Registration Number -12), and Medline Micro-Kill (Trademark) Bleach Germicidal Bleach Wipes (EPA Registration Number -1). Review of the Lysol Disinfecting Wipes (EPA Registration Number 777-114), effective date 3/1/12, revealed Lysol Disinfecting Wipes could be used to clean and disinfect household surfaces. Lysol Disinfecting Wipes used on non-porous surfaces killed Salmonella [MEDICATION NAME] (Salmonella), Influenza [MEDICAL CONDITIONS] Simplex Virus Type 1, Respiratory [MEDICAL CONDITION], including 8 cold & flu viruses in 10 minutes. Lysol Disinfecting Wipes were also safe to use on electronics including smart phones, tablets and remote controls. Review of the clinical record for R#4 revealed she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED].#4 was to have an Accucheck to be completed before meals. Observation of Registered Nurse (RN) #1 on 6/24/2020 at 11:30 a.m., revealed she retrieved the glucometer from the medication cart, set it on top of the medication cart without disinfecting it, then performed the FSBS for R#4. Continued observation revealed that after completing the FSBS for R#4 RN #1 disinfected the glucometer with a Lysol Disinfecting Wipe. Interview with RN #1 on 6/24/2020 at 4:28 p.m., revealed she was hired on 5/26/2020 and was precepted by a nurse at the facility which included instruction on FSBS. RN #1 stated she should have disinfected the glucometer prior to and after performing the FSBS for R#4 with Micro-Kill. RN #1 stated that the Lysol wipes were used to clean the medication cart and stored in the bottom drawer with the Micro-Kill. RN #1 stated that the Micro-Kill bottle wasn't on the medication cart at the time she performed the FSBS, that's why she used the Lysol wipe to disinfect the glucometer. However, RN #1 stated she should have asked the other nurse working the B Hall for the Micro-Kill and should have checked the Lysol wipe label to ensure it's approved for use on the glucometer. RN #1 also stated she didn't follow proper infection control procedures for disinfecting the glucometer. Further interview with RN #1 revealed the purpose of disinfecting the glucometer was to prevent cross contamination from infections and blood borne pathogens. Interview with LPN #2 on 6/24/2020 at 1:25 p.m., revealed she had precepted RN #1. LPN #2 stated that glucometers should be cleaned in between each resident with Micro-Kill to remove germs and blood and bodily fluids. Further interview revealed it was the nurse's responsibility to ensure that Micro-Kill was available on their medication cart for disinfecting the glucometers along with Lysol wipes to clean the medication cart. Interview with the Assistant Director of Nursing (ADON) on 6/24/2020 at 2:39 p.m., revealed she expected nursing staff to use Micro-Kill to disinfect the glucometers to limit exposure of bacteria and blood borne pathogens. The ADON further stated Lysol wipes were not approved for cleaning the glucometers but should be used to clean the medication carts. Interview with the Director of Nursing (DON) (who also served as the Infection Control Preventionist) on 6/24/2020 at 2:00 p.m., revealed the glucometer should be disinfected between each resident using Micro-Kill for one (1) minute prior to being put back into the medication cart drawer. The DON stated that RN #1 had not followed the facility's policy for cleaning the meter. Interview with the Regional Nurse Consultant (RNC) on 6/24/2020 at 5:00 p.m., revealed the purpose of the infection control policy was to prevent transmission of blood borne pathogens and cross contamination. The RNC stated that the nurses were trained and expected to use Micro-Kill for cleaning and disinfecting the glucometers as stated in the policy and procedure.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.