STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235330	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF LIVINGSTON	3003 W GRAND RIVER HOWELL, MI 48843

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 -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 443. Based on observation, interview and record review, the facility failed to properly follow and maintain accepted standards of infection control as per the Centers for Disease Control and Prevention (CDC) during a COVID-19 outbreak in the facility including, but not limited to failure to: (1) Immediately isolate and segregate residents who tested positive for the COVID-19 virus; (2) Segregate staff caring for COVID-19 positive and/or symptomatic residents from staff caring for asymptomatic residents; (3) Ensure Personal Protective Equipment (PPE) was used to prevent potential transmission of infectious organisms, including COVID-19; (4) Operationalize, implement, and maintain components of a comprehensive Infection Control program, including COVID-19 infection, comprised of documentation, collection and analysis of surveillance data to identify and track trends and patterns of residents and employee infections as well as identify infection and implement Transmission Based Isolation Precautions in a timely manner for three residents (#1, #6 and #13); and the facility failed to (5) Assure licensed nurses followed manufacturer's recommendations for disinfecting glucometers using EPA (Environmental Protection Agency) registered disinfectants or germicidal wipes for six of six residents reviewed (#7, #8, #9, #10, #11 and #12), resulting in the potential for spread of COVID-19 and transmission of blood borne pathogens. Findings include: On 3/9/2020 the Centers for Medicare and Medicaid Service (CMS) and the CDC released guidance for Long Term Care facilities related to prevention and management of COVID-19 to protect their residents and staff from infection. Since this release, the CDC has modified their COVID-19 management recommendations as more has been learned. On 3/11/2020, The World Health Organization (WHO) declared the novel coronavirus (COVID-19) outbreak a global pandemic. According to michigan.gov/coronavirus, the total reported COVID-19 cases in Michigan between 3/1/2020 and 3/15/2020, had reached 1,845. As of 4/20/2020, there was a total of 2058 confirmed cases in Region 3 (local region), and a total of 31,029 confirmed cases in the State of Michigan. A review of the SOM reflected .RECOGNIZING, CONTAINING AND REPORTING COMMUNICABLE DISEASE OUTBREAK .Refer to CDC guidelines for current recommendations on standard and transmission-based precautions .INFECTION CONTROL POLICIES AND PROCEDURES .The facility must develop and implement written policies and procedures for the provision of infection prevention and control. The facility administration and medical director should ensure that current standards of practice based on recognized guidelines are incorporated in the resident care policies and procedures . According to the CDC's memo labeled QSO-20-14-NH and dated 3/13/20, Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, reflected, This guidance included detailed information regarding recommended PPE . HCP (Health care providers) who enter the room of a patient with known or suspected COVID -19 should adhere to Standard Precautions and use a respirator (or facemask if a respirator is not available), gown, gloves, and eye protection (droplet precautions) .Gowns; Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use. If there are shortages of gowns, they should be prioritized for: aerosol generating procedures, care activities where splashes and sprays are anticipated, high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCP. Examples include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care. This memo provided several links to useful tools for facilities to utilize including a PPE Burn Rate Calculator (to help determine how much PPE was utilized). No evidence was provided that facility utilized tools to monitor supplies. A review of the CDC's Strategies for Optimizing the Supply of Isolation Gowns, dated 3/17/20, reflected, under Extended use of isolation gowns. Consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same HCP when interacting with more than one patient known to be infected with the same infectious disease when these patients are housed in the same location (i.e., COVID-19 patients residing in an isolation area). This can be considered only if there are no additional co-infectious [DIAGNOSES REDACTED]. If the gown becomes visibly soiled, it must be removed and discarded as per usual practices. CMS and the CDC sent out recommendations for Long Term Care Facilities (LTC) to help mitigate the spread of COVID-19 as follows: 1. Nursing Homes should ensure that they are complying with all CMS and CDC guidance control: In particular, appropriate hand hygiene. Extensive infection control guidance, including a self-assessment checklist that long-term care facilities Facilities should also refer to the CDC's guidance for long-term care facilities on COVID-19 and guidance on conservation of PPE. 2. As long-term care facilities are a critical part of the healthcare system, and because of the ease of spread in long-term care facilities and the severity of illness that occurs in residents with COVID-19, CMS urges State and local leaders to consider the needs of long-term care facilities with respect to supplies of PPE and COVID-19 tests. 3. Long-term care facilities should immediately implement symptom screening for all: Every individual should be asked about COVID-19 symptoms and temperature checked . Every resident should be assessed for symptoms and have their temperature checked every day. Patients and residents who enter facilities should be screened for COVID-19 through testing, if available . 4. Long-term care facilities should ensure all staff are using appropriate PPE when they are interacting with patients and residents, to the extent PPE is available and per CDC guidance on conservation of PPE: All long-term care facility personnel should wear a facemask while they are in the facility. Full PPE should be worn per CDC guidelines for the care of any resident with known or suspected COVID-19 per CDC guidance on conservation of PPE. If COVID-19 transmission occurs in the facility, healthcare personnel should wear full PPE for the care of all residents irrespective of COVID-19 [DIAGNOSES REDACTED]. To avoid transmission within long-term care facilities, facilities should use separate staffing teams for COVID-19-positive residents to the best of their ability, and work with State and local leaders to designate separate facilities or units within a facility to separate COVID-19 negative residents from COVID-19 positive residents and individuals with unknown COVID-19 status: Long-term care facilities should exercise as best as possible consistent assignment regardless of symptoms or COVID-19 status. Long-term care facilities should separate patients and residents who have COVID-19 from patients and residents who do not or have an unknown status. When possible, facilities should exercise consistent assignment, or have separate staffing teams for COVID-19-positive and COVID-19-negative patients. According to the facility policy statement, reviewed 3/2020, and titled. Personal Protective Equipment (PPE), Standard Precautions shall be used when caring for residents at all times regardless of their suspected or confirmed infection status. Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable disease or infections that can be transmitted to others .Airborne Precautions will be implemented for anyone who is documented or suspected to be infected with microorganisms transmitted by airborne droplet nuclei (small-particle residue of evaporated droplets containing microorganisms that remain suspended in the air and can be widely dispersed by air currents within a room or over a long distance. 8. [MEDICAL CONDITION] (Covid-19) was listed as requiring Airborne precautions. 50. In addition to wearing a gown .wear a gown (clean, nonsterile) for all interactions that may involve contact with the resident or potentially contaminated items in the resident's environment. Remove the gown and perform hand

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) hygiene before leaving the resident's environment. A review of a facility policy, dated 3/11/20 and titled, Coronavirus Surveillance, reflected the following: Under, Policy: This facility will implement heightened surveillance activities or coronavirus illness during periods of transmission in the community and/or during a declared public health emergency for the illness: Under, Policy Explanation and Compliance Guidelines .2. Heightened surveillance activities will be implemented to limit the transmission of COVID-19. These include, but are not limited to, screening visitors, staff, and residents. 3. Screening for visitors and staff: a. Signs or symptoms of a respiratory infection, such as fever, cough, new onset or unusual shortness of breath, or sore throat. 6. Residents will be monitored for signs and symptoms of coronavirus illness: fever, cough, shortness of breath . Staff shall follow established procedures when COVID-19 is suspected. 7. Residents will be monitored for signs and symptoms of coronavirus illness: fever, cough, shortness of breath .Staff shall follow established procedures when COVID-19 is suspected .c Increase monitoring of resident for development of more severe symptoms or other changes in condition. d. Increase monitoring of all other residents when COVID-19 is suspected or confirmed. The policy failed to say how often assessments and monitoring would be done for residents and staff, and what established procedures shall be followed when COVID-19 was suspected. During an observation and interview on 6/9/20 at 9:10 a.m., this surveyor entered the facility after Administrator (ADM) A reported being a HUB facility and currently had one possible COVID positive resident on the dedicated COVID Unit that was just inside the main entrance of the facility. The COVID unit had closed doors to the unit with stop signs posted to prevent entry. ADM A reported Licensed Practical Nurse (LPN) I was the nurse for Hall C and the COVID Unit that day. ADM A reported all staff had the ability to use Facetime technology if needed. During an interview on 6/9/20 at 9:33 a.m. while touring the memory unit (200 hall), Certified Nurse Aid (CNA) b reported working at the facility for one and a half years and most often on the memory unit. CNA b reported that, currently, all staff were screened (asked a specific set of questions and temperature taken) by the receptionist before entering the facility at the front reception door with mask on prior to entering the building and at the end of each shift. CNA b reported residents are screened about symptoms and vitals taken and reported to the nurse. every shift (two times daily). CNA b reported staff wore full Personal Protective Equipment (PPE) during the time residents in the Memory Unit tested positive for COVID except for four residents who were moved to a different unit. When asked, CNA b reported full PPE was a reusable gown, face shield, N95 mask that was kept by the Memory Unit Nurse Station on hooks located on the wall adjacent the Nurse Station and masks were kept in paper bags. Several white plastic hooks were noted lined up on the wall across from the centrally-located Nurse Station next to the open common area. CNA b reported each staff member had their own gown, face shield and N95 to be reused for seven days between all residents (positive and unknown residents) on the Memory Unit after the first known positive COVID resident was diagnosed . CNA b reported the facility had enough PPE for staff. During an interview on 6/9/20 at 9:50 a.m., it was conveyed that the memory unit was tested . LPN K reported all residents on the Memory Unit were already on droplet isolation at that time before R6 tested positive for COVID-19. LPN K reported after the entire unit was tested , four residents were negative for COVID-19, and all others tested positive for COVID-19. LPN K reported the four negative residents were moved to another unit. LPN K reported staff wore full PPE that included reusable heavy gown, face shield, N95 mask between all residents for seven days before receiving new PPE and changed gloves between each resident after first known positive COVID-19 at the facility. LPN K denied concerns with enough PPE and reported management are responsible for notifying resident families with COVID updates. Resident #1 (R1) According to the facility electronic medical records, R1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS-resident assessment), dated 2/18/20, R1 had severe cognitive impairment, and resided in the memory care unit. R1 was diagnosed with [REDACTED]. Prior to this, per interview, nursing staff were wearing the same gowns and masks in all residents' rooms on the memory care unit. R1 was provided with hospice services starting on 4/23/20 and passed on 5/14/20. The death certificate cited Covid-19 as the cause of death. Resident #6 (R6) A review of the face sheet and MDS dated [DATE], reflected R6 was a [AGE] year old male admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The MDS reflected R6 had severely impaired decision-making ability, required one person physical assist with bed mobility, transfers, locomotion on the unit, dressing, hygiene, bathing and two person physical assist with toileting. During a telephone interview on 6/9/20 at 10:51 a.m., LPN I reported her assignment that day was rooms 300 to room [ROOM NUMBER] that included the COVID Unit with one resident at that time in room [ROOM NUMBER]. LPN K reported the one resident that was positive for COVID-19 (R6) was admitted on [DATE]. This surveyor requested a Facetime tour of the COVID unit and was told LPN K was unsure how to do that, and ADM A was heard in the background saying that he would call this surveyor for the tour. During Facetime tour of the Covid Unit and interview on 6/9/20 at 11:06 a.m., with ADM A and LPN K. Both had full PPE on including gown, N95 mask, eye protection and gloves. This surveyor observed the entrance to the COVID positive unit was identified by black and yellow tape on floor and walls with signs in place. room [ROOM NUMBER] was the first resident door on the unit with only one COVID positive resident and the door was noted to be closed. ADM A reported hooks on wall at start of COVID unit is where the gowns are hung for the nurse and CNA for use during the entire shift. ADM A reported the facility became a licensed COVID-19 HUB on 4/27/20. A review of R6's Electronic Medical Record (EMR) vital signs, reflected R6 had documented temperatures that included: 4/4/20 at 4:31 a.m. of 100 degrees 4/5/20 at 1:15 a.m. 102.5 degrees (21 hours later) 4/5/20 at 8:37 p.m. 101.6 degrees 4/6/20 at 4:07 a.m. 101.6 degrees 4/7/20 at 2:45 p.m. 101.4 degrees Continued review of R6's EMR reflected no documentation for temperatures for either shift on 4/1/20 or 4/2/20. A review of the facility EMR doctor orders, dated 4/1/20 through 6/9/20, reflected R6 had no mention of droplet isolation until 4/15/20. A review of facility lab results, dated 4/7/20, reflected R6 tested positive for COVID-19. A review of care plans, dated 3/16/20 through 6/9/20, reflected R6 droplet isolation precautions were started on 4/14/20, seven days after the positive Covid diagnosis. A review of the facility COVID Line List (method for the infection preventionist to track and trend infections, dated 3/20/20 through 5/25/20, reflected both resident and staff data without mention of resident name, room number and dates when Covid test results were received. Continued review of data reflected 22 in-house transmission COVID-19 positive residents and 11 Covid-positive staff between 3/30/20 and 5/20/20. The data reflected R6 tested positive on 4/6/20. Review of the Minimum Data Set (MDS) data and the Medical Record, reflected R13 resided in the Memory Unit, tested positive for COVID-19 on 4/03/20, sent to the hospital 4/08/20 and returned to the facility 4/10/20. A review of physician orders [REDACTED]. According to Administrator A, on 06/16/2020 11:05 AM, All residents in the facility were in droplet precautions as of the first date COVID was in the building. All rooms had the postings and doors were kept closed and staff in full PPE (Personal Protective Equipment) including gloves, gowns, N95 mask and eye protection prior to (R13) testing positive. She (R13) did return to (Dementia Unit). At that time the entire 200 unit (memory unit) was in droplet precautions. I will have to look at the EMR (electronic medical record) to confirm dates of orders for precautions, care plans etc. No further clarification was provided by Administrator A. During a telephone interview on 6/11/20 at 9:50 a.m. Activity Manager (AM) U reported working at the facility for over three years. AM U reported group activities were restricted starting in March and reported activity staff did more 1:1 activities in rooms, hall bingo, video chats, window visits, frequent checks, activity carts and busy packets with single use items used. AM U reported she did test positive for COVID on 4/10/20 after becoming symptomatic and was off for a couple of weeks. AM U reported prior to 4/10/20, they were not wearing a gown and face shield in each room. After return to work on 4/22/20, AM U used full PPE (gown, mask and eye protection) for every resident. AM U denied any shortage of PPE. During a telephone interview on 6/11/20 at 10:21 a.m., Physical Therapy Assistant (PTA) V reported working at the facility for five to six years. PTA V reported staff all wore full PPE (gown, N95 mask and eye protection) all day with glove changes only between residents after first case of COVID-19 was discovered in the facility and the entire building was on isolation. During a telephone interview on 6/11/20 at 11:47 a.m., Infection Control Nurse (IC) C reported working as infection control nurse since February 2019. IC C reported the first facility case of COVID-19 occurred on 3/30/20, and the resident was symptomatic, sent to the hospital and tested positive for COVID-19 there. IC C reported the entire building was placed on droplet isolation precautions. IC C reported staff were screening residents at that time by checking temperatures every shift and symptoms documented by exception. If residents developed a fever, the nurse was expected to call physician and orders were followed. IC C reported R6 had a fever on 3/29/20 and the physician ordered chest X-ray and antibiotics. R6 was transferred to the hospital on [DATE] for respiratory distress. IC C was unable to say when droplet isolation precautions were actually started for the entire facility. A review of the, Coronavirus Disease (COVID-19) Preparedness Checklist for Nursing Homes and other Long Term Care Settings, completed and signed on 4/15/20 by the facility, reflected several resource links for faculties to utilize. The Check list was made available to facilities on 4/2/20. During a telephone interview on 6/11/20 at 4:42 p.m., Unit Manager Q for Hall C and Memory Unit reported residents are screened for COVID-19 every shift by monitoring temperatures and if resident has a fever over 100 degrees nurses were expected to call the

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) physician. Unit Manager Q reported she was unsure what Person Under Investigation for COVID meant. During a telephone interview 6/12/20 at 8:41 a.m., LPN J reported routinely worked on the ventilator unit but occasionally worked on Memory unit. LPN J reported was currently the Memory Unit nurse. LPN J reported unsure when facility started using N95 but early along with gowns as well and reported resident COVID screen completed every shift with temperature and documented any abnormal symptoms and notified Physician. LPN J reported staff had protocol that included to start supplements. LPN J reported when entire facility on isolation all doors remained closed and one resident on the ventilator unit was COVID positive with tape on the floor and PPE outside door with change of PPE for that resident. During a telephone interview on 6/12/20 at 9:10 a.m., IC C reported the Infection Control Line Listing for April and May including data from June, July and August 2019 and would provide correct data. Second request for COVID Protocol was made. IC C reported after first case of positive COVID-19 on 3/30/20 staff wore same full PPE entire shift (including between known and unknown positive COVID-19 residents) with only change of gloves between each resident and reused PPE for seven days. When asked, How did that protect the residents who had not tested positive for COVID or were asymptomatic? IC C reported she was unsure but staff did what corporate advised them to do and also kept same staff to each unit. IC C reported she was unsure why Infection Control line listing did not include room numbers. The facility was asked to provide Infection Control document that showed evidence of infection control tracking with all needed data including resident, location (room number), date tested , results received with date on 6/12/20 at 11:00 a.m. DON B responded by email, I will see what I can do about the dates and room numbers on the same document . During a telephone interview on 6/16/20 at 9:11 a.m., LPN c reported being off three weeks in April and returned to work 4/20/20. LPN c reported worked on the ventilator unit and used full PPE first week of April. When this surveyor asked, who did that protect, and how did that protect residents? LPN c stated, not sure, was just following rules at the time. LPN c reported currently if residents develop more than one COVID symptom she would contact DON, ADM, Physician and if temperature over 100 degrees most likely isolate resident for 72 hours but ADM and DON make that choice. A review of the facility Infection Control Line list, dated April 2020 and May 2020 as well as the COVID line list dated March 2020 through May 2020, reflected no document with complete Infection Control tracking information including resident name, location (room number), date tested , dated COVID-19 results returned .The CDC provided recommendation to Long Term Facilities, dated 4/2/20, that included guidance and tools to use for tracking COVID-19 respiratory cases; found online at: https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources. During an interview on 6/16/20 at 12:00 p.m., Director of Nursing (DON) B reported residents are currently being screened for COVID-19 symptoms every shift and documenting on the Medication Administration Record. DON B reported if residents have symptoms including fever over 100 degrees staff are expected to notify the Physician, DON B, IC nurse C, and the ADM A. DON B reported after the first known COVID positive case on 3/30/20 the facility started full PPE (gown, face shield, and N95 mask) for all staff with all doors closed, and the entire building was on droplet isolation. DON B reported that meant all staff wore the same full PPE (gowns and masks) all shift, without changing gowns between resident rooms for seven days, except gloves were changed between residents. DON B reported was able to get five to six residents tested for COVID at a time, and tested the most symptomatic residents first until all residents on the memory unit were tested on [DATE]. DON B reported they had an issue with one lab that did not get results back for 5 day, so they changed labs. DON B reported daily counts of PPE were being monitored and staff reused PPE for seven days starting on 3/30/20. DON B reported they did not have a lot of PPE at first, as time passed they got a lot. DON B reported they considered all residents COVID positive on the memory unit after the first case on 3/30/20, until all testing was negative, regardless if they had symptoms or not. DON B reported some residents did not have symptoms. DON B reported when entire unit (memory unit) tested on [DATE] four residents came back COVID positive and were moved to he dedicated COVID unit on 5/6/20 . ON 6/16/20 at 2:20 PM, ADM A was asked to provide evidence of the PPE counts and what measures were taken to obtain additional supplies starting in April 2020. ADM A had reported they utilized the Crisis Capacity Strategies for extended use of isolation gowns. (which required evidence of measures taken to obtain additional supplies and current use of supplies) ADM A provided daily PPE counts that reflected 4/1/20 supplies included 667 gown (50 used daily), 160 N95 masks (110 used weekly), 20 face shields with no data collected for daily use. The numbers collected do not match information obtained from staff interviews related to reuse of gowns and masks for 7 days. ADM A provided an email, dated 3/25/20, from a physician who had reached out to the facility's Senior Director of Marketing & Admissions to inquire if they would like donations of face masks and shields from local school PPE drive. with evidence that email had been shared with ADM A on 3/27/20. ADM A provided one email, dated 3/17/20, as evidence of one attempt to obtain additional supplies from the facility's corporate emergency manager. No additional dated evidence was provided by the ADM A related to what steps were taken to obtain additional PPE by end of survey on 6/23/2020. Glucometer cleaning In an interview and observation, on 6/09/20 at 9:10 AM, Registered Nurse (RN) D, working on the 400 Hall/Ventilator Unit demonstrated how she cleaned the glucometer (a hand held device that detects the amount of glucose/sugar in a sample of blood). RN D said, I clean them (glucometers) with alcohol wipes. RN D took an alcohol packet, opened it and wiped the glucometer. I've been here three months. I thought bleach wasn't good for it. I didn't know a thing about how long to keep them wet. The Director of Nursing (DON) B, standing nearby, corrected RN D telling her to use the bleach wipes, not an alcohol pad. DON B said, The nurses she (RN D) was training with should have taught her that. In a second interview via telephone, on 6/09/20 at 1:27 PM, RN D reported she started, full-time, at the facility on the night shift three months ago, came to the day shift two weeks ago, and had worked on the 400 Hall (Ventilator Hall) and the 500 Hall. RN D reported that while working the night shift, she performed approximately four - six blood sugar (glucose) checks using a glucometer each night; while on the day shift, she performed glucose checks at noon on an as needed basis. RN D reported that Licensed Practical Nurse (LPN) L trained her to use alcohol wipes, not bleach wipes to sanitize the glucometers. In a telephone interview, on 6/09/20 at 1:39 PM, LPN L reported she had worked full-time at the facility for [AGE] years and currently worked the 6:30 PM - 7:00 AM shift. LPN L stated she had been training new nurses for the past year (including LPN N and RN D). LPN L said, I wipe (the glucometer) with alcohol and let it sit one minute before using it again. I do that before and after it is used. I set it on top of my paperwork (no barrier). LPN L stated she had been checked off glucometer use and was using alcohol then (at the time she was approved) by RN M who worked on the 500 Hall. LPN L stated she performed three - four blood glucose checks each night with a glucometer. In a telephone interview, on 6/09/20 at 2:15 PM, LPN N reported she worked the 400 Hall full-time night shift and said, I clean (the glucometer) with alcohol wipes or bleach wipes. I've been using alcohol wipes. LPN N stated the following residents resided on the 400 Hall required blood sugar checks: Medication Cart I: (Residents #7, #8) and Medication Cart II: (Residents #9, #10 and #11). In a telephone interview, on 6/10/20 at 7:47 AM, RN M reported she worked the 500 Hall and said, I usually use a bleach wipe before and after. I think you'd have to wipe it down multiple times if you used an alcohol wipe. RN M reported RN P performed her Performance Review and cleared her on proper use of the glucometer. RN M stated, If she didn't have me demonstrate, then it was a talk-through. Review of Medical Records revealed RN D, LPN N and LPN L all performed blood sugar checks on 400 Hall Residents #7, #8's #9, #10 and #11 within the past two months. Review of Medical Records revealed RN D, LPN N and RN M all performed blood sugar checks on 500 Hall Resident #12 in the past two months. In a telephone interview, on 6/10/20 at 7:57 AM, RN P stated she used a bleach wipe before and after using the glucometer and kept it wet for two - six minutes. RN P confirmed when training new staff, If they have time, I watch them, but if not, I talk it though with them. According to the facility's Glucometer Disinfection Policy and Procedure, not dated, .The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use . The glucometers should be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective [MEDICAL CONDITION](Human immunodeficiency virus), [MEDICAL CONDITION] and [MEDICAL CONDITION] virus . The policy/procedure did not address the use of a barrier to prevent cross-contamination. According to the glucometers manufacturer's instructions, Option 1: Cleaning and disinfecting can be completed by using a commercially available EPA -registered disinfectant detergent or germicide wipe . Many wipes act as both a cleaner and disinfectant, though if blood is visibly present on the meter, two wipes must be used, use one wipe to clean and a second wipe to disinfect. Option 2: To clean the outside of the blood glucose meter, use a lint-free cloth dampened with soapy water or [MEDICATION NAME] alcohol (70-80%). To disinfect the meter, dilute 1 ml bleach (5-6% sodium hypochlorite solution) in 9 ml of water to achieve a 1:10 dilution (final concentration of 0.5-0.6% sodium hypochlorite). The solution can then be used to dampen a paper towel (do not saturate the towel). Then use the dampened paper towel to thoroughly (sic) wipe down the meter. Please note that there are commercially available 1:10 bleach wipes from a variety of manufacturers . According to the Centers for Disease Control (CDC), March 2, 2011, Infection Prevention during Blood Glucose Monitoring and Insulin Administration: .An

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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 -** Many	(continued... from page 3) under-appreciated risk of blood glucose testing is the opportunity for exposure to [MEDICAL CONDITION] (HBV, [MEDICAL CONDITION] virus, [MEDICAL CONDITION].through contaminated equipment and supplies if devices used for testing and/or insulin administration (e.g., blood glucose meters, fingerstick devices, insulin pens) are shared. Outbreaks of [MEDICAL CONDITION] virus (HBV) infection associated with blood glucose monitoring have been identified with increasing regularity, particularly in long-term care settings, such as nursing homes and assisted living facilities, where residents often require assistance with monitoring of blood glucose levels and/or insulin administration. In the last [AGE] years, alone, there have been