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	145596	A. BUILDING _____ B. WING _____	03/11/2013

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SNYDER VILLAGE	1200 EAST PARTRIDGE METAMORA, IL 61548

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F 000	INITIAL COMMENTS Annual License and Certification Subpart U in Substantial Compliance	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to operationalize their Physical Restraint Management and Reduction policy by providing a medical symptom for the use of restraints for three of four residents (R2, R6, and R22) reviewed for physical restraints. Findings include: Facility's Physical Restraint Management and Reduction policy dated 01/01/12 documents an individualized restraint reduction program must be documented on the care plan with the type of restraint, duration of use, circumstances under which restraint may be used R22's current Physician Order Sheet dated 03/01/13 through 03/31/13 documents, "wheelchair with seat belt release belt and reposition every two hours." R22's Physical Restraint Informed Consent dated 11/07/12 documents a wheelchair with a seatbelt	F 221		

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

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F 221	Continued From page 1	F 221		

to be used for restlessness and to provide an activity/diversion and documents the reason used "as a therapeutic intervention." The consent does not have an appropriate medical symptom documented.

On 03/07/13 at 2:42 p.m., E3, ADON (Assistant Director of Nursing) confirms that R22's current care plan does not document R22's seatbelt as a problem with a reduction plan and interventions. E3 also confirmed that the physician's order does not document an appropriate symptom for restraint use.

On 03/07/13 at 1:50 p.m., R22 was propelling self in a wheelchair in the hallway of the facility's locked unit. E11, LPN (Licensed Practical Nurse) asked R22 to unfasten the seatbelt and R22 was unable to complete this task.

R2's Physician Order Sheet dated 03/01/13 through 03/31/13 documents, "self releasing seatbelt."

R2's Physical Restraint Informed Consent dated 01/28/13 documents, "self release seat belt used while in wheelchair to provide an opportunity for increased functioning."

On 03/07/13 at 8:07 a.m., R2 was sitting upright in the wheelchair at the breakfast table in the common area of the facility's locked unit. R2's seatbelt was secured. Breakfast was sitting on the table in front of R2. R2 was looking down at the seatbelt attempting to unfasten it.

On 03/07/13 at 1:45 p.m., E11, LPN asked E12, CNA (Certified Nurse's Aide) if R2 was able to

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F 221	Continued From page 2 unfasten the seatbelt when asked and E12 answered, "No. I don't think so." E11 also stated, "We (facility staff) keep R2's belt fastened while (R2) is at the breakfast table because (R2) leans forward so much." E11 then confirms that R2's seatbelt does not prevent the resident from leaning forward. R6's Physician Order Sheet dated 03/01/13 through 03/31/13 documents wheelchair with laptop cushion as needed for agitation or extreme restlessness but gives no indication of a medical symptom related to the use of the restraint. On 03/06/13 at 4:07 p.m., R6 was sitting in a wheelchair near the nurse's station in the common area of the facility's locked unit with a laptop cushion in place. Several residents and staff members were present in this same area. R6 was calm in appearance and readily smiled. E13, LPN stated that R6 was getting agitated and that R6 had been given a dose of Ativan (anti-anxiety medication) and that staff attempted to get R6 to fold laundry. E13 then stated, "We put (R6) in the wheelchair with the laptop cushion. I think the increased amount of people agitated (R6)." On 03/07/13 at 2:42 p.m., E3, ADON confirms that R6, "shouldn't have been restrained at the nurse's station if the increased amount of people is what agitated her. We (facility staff) use it (laptop cushion) when (R6) is confused and combative."	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		

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F 225	Continued From page 3 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 225		

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F 225	Continued From page 4 Based on interview and record review the facility failed to immediately report allegations of abuse to the administrator for two of three abuse allegations reviewed. Findings include: The Facility's staff report form dated 7/8/12 documents R34 reported an allegation of physical abuse. The facility's Initial 24 Hour Abuse/Neglect Allegation form documents E1 (Administrator) was notified of the allegation on 7/9/12 at 8:00 a.m.This allegation was not reported to the Administrator immediately. The Facility's Supervisors report documents on 2/17/13 at 10:30AM, R35's family reported an allegation of abuse to the facility. The Facility's Abuse/Neglect Allegation Final Report documents the initial report date was 2/18/13 and the report was initiated by E1. This allegation was not reported to the Administrator immediately. On 3/7/13 E1 acknowledged the Abuse Allegations on 7/8/12 and 2/18/13 were not reported immediately to E1 according to the documentation.	F 225		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's	F 279		

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medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on interview, observation, and record review, the facility failed to care plan contact isolation for one resident (R14) and failed to care plan restraint use for two residents (R2 and R6) sampled for care plans in the sample of 19.

Findings include:

1. The care plan for R14 dated 02/18/2013 identifies Ecoli in the urine. This same care plan does not include any reference to the contact isolation initiated or interventions, goals or approaches related to these needs.

E3 (Assistant Director of Nursing) stated 03/07/2013 at 02:04 PM "I would expect to see an entry regarding contact isolation on the care plan...I don't know why it was excluded."

2. R6's Physician Order Sheet dated 03/01/13 through 03/31/13 documents, "wheelchair with lap

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F 279	Continued From page 6 top cushion as needed for agitation, extreme restlessness. Remove every two hours." On 03/06/13 at 4:10 p.m., R6 was sitting in a wheelchair with a lap top cushion in place near the facility's locked unit's nurse's station. R6's current care plan was reviewed and did not indicate the wheelchair with lap top cushion as a problem with goals and interventions. On 03/07/13 at 2:42 p.m., E3 confirms that no reference to the wheelchair with lap top cushion is documented on R6's current care plan. 3. R2's Physician Order Sheet dated 03/01/13 through 03/31/13 documents, "reclining wheelchair with tray removed as needed-reposition every two hours. Self releasing seatbelt." R2's current care plan was reviewed and did not indicate the reclining wheelchair with lap top cushion or the self releasing seatbelt as a problem with goals and interventions. On 03/07/13 at 2:42 p.m., E3 confirms that the reclining wheelchair with tray and the self releasing seatbelt were not identified as a problem on R2's current care plan.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		

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F 280	Continued From page 7 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to care plan new interventions after falls for eight of 19 residents (R2, R6, R7, R11, R12, R18, R20, and R22) reviewed for care plans in the sample of 19. Findings include: 1. Facility Fall Risk Prevention and Monitoring Policy dated September 2007 documents for staff to implement resident specific interventions to prevent further occurrences, care plan the event on the care plan and add interventions to the resident's care guide. R18's Fall Risk Assessments dated 12/12/12 and 12/27/12 document R18 is at high risk for falls. On 03/05/13 at 9:13 a.m., R18 was resting in bed with a significant amount of facial bruising and a	F 280		

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Velcro knee immobilizer secured in place on her right knee. E3, ADON (Assistant Director of Nursing) stated, "(R18) fell last night. Facility's Incident Reports document R18 fell on 12/22/12 and 03/01/13. No interventions for these falls were documented on R18 ' s current care plan dated 12/12/12.

R18's current care plan dated 12/12/12 documents, "Resident is at risk for falls," and has no new approaches documented since 12/12/12.

On 03/07/13 at 8:15 a.m., R18 was sitting in a wheelchair in the facility's secured unit's common area. R18 had a large amount of bruising to the face and R18 was repositioning R18's right leg which had a Velcro knee immobilizer fastened in place.

On 03/07/13 at 10:28 a.m., E3, ADON confirmed that R18's care plan had not been updated after R18 fell on 12/22/12 and 03/01/13 and stated, "They (new approaches for R18) should have been on the care plan."

2. R6's Fall Risk Assessments dated 09/04/12 and 12/20/12 document R6 is at high risk for falls.

On 03/05/13 at 1:31 p.m., R6 was sitting at a table in the facility's secured unit's common area. E9, CNA (Certified Nurse's Aide) sat a basket of laundry in front of R6. R6 began folding the laundry.

Facility Incident Reports document R6 fell on 10/06/12, 11/20/12, 01/26/13, and 02/15/13. No interventions for these falls were documented on R6's current care plan dated 09/04/12.

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On 03/07/13 at 10:28 a.m., E3, ADON confirmed that R6's care plan had not been updated after R6 fell on 10/06/12, 11/20/12, 01/26/13, and 02/15/13 and stated, "They (new approaches for R6) should have been on the care plan."

3. R22's Fall Risk Assessments dated 09/12/12, 12/06/12, and 02/27/13 document R22 is at high risk for falls.

On 03/06/13 at 4:00 p.m., R22 was sitting in a wheelchair with a seatbelt fastened propelling down the hallway in the facility's locked unit.

Facility Incident Reports document R22 fell on 10/14/12, 01/04/13, and 01/05/13. No interventions for these falls were documented on R22's current care plan dated 10/11/12.

On 03/07/13 at 10:28 a.m., E3, ADON confirmed that R22's care plan had not been updated after R22 fell on 10/14/12, 01/04/13, and 01/05/13 and stated, " They (new approaches for R22) should have been on the care plan. "

4. R2's Fall Risk Assessments dated 04/25/12, 07/25/12, 10/25/12, and 01/10/13 document R2 is at high risk for falls.

On 03/07/13 at 8:07 a.m., R2 was sitting in a wheelchair in the common area of the facility's locked unit. R2 had a seatbelt secured with a seatbelt alarm in place. R2 was attempting to remove the seatbelt.

Facility Incident Reports document R2 fell on 05/24/12, 06/21/12, 09/11/12, 10/18/12, 10/29/12,

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11/07/12, and 03/02/13. No interventions for these falls were documented on R2's current care plan dated 10/25/12.

On 03/07/13 at 10:28 a.m., E3, ADON confirmed that R2's care plan had not been updated after R2 fell on 05/24/12, 06/21/12, 09/11/12, 10/18/12, 10/29/12, 11/07/12, and 03/02/13 and stated, "They (new approaches for R2) should have been on the care plan."

5. R7's Fall Risk Assessments dated 04/17/12, 08/12/12, 11/01/12, and 01/05/13 document R7 is at high risk for falls.

On 03/05/13 at 1:40 p.m., R7 was ambulating with a walker in the hallway of the facility's locked unit and sat down in a chair of the common area.

Facility Incident Reports document R7 fell on 06/20/12 and 09/12/12. No interventions for these falls were documented on R7's care plan dated 05/09/12.

On 03/07/13 at 10:28 a.m., E3, ADON confirmed that R7's care plan had not been updated after R7 fell on 06/20/12 and 09/12/12 and stated, "They (new approaches for R7) should have been on the care plan."

6. A facility fall investigation form dated 5-12-12 and 9-15-12 documents that R11 fell on those dates. R11's fall prevention care plan dated 12-06-11 does not include fall prevention measures initiated for those dates, nor does it include the evaluation of the effectiveness of previous fall prevention measures.

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F 280	Continued From page 11 7. A facility fall investigation form dated 6-04-12 and 8-02-12 documents that R12 fell on those dates. R12's fall prevention care plan dated 8-01-07 does not include fall prevention measures initiated for those dates, nor does it include the evaluation of the effectiveness of previous fall prevention measures. 8. The Facility's incident forms dated 3/3/13, 6/7/12, and 7/2/12 document R20 had falls. R20's most recent care plan documented at risk for falling related to fall assessment dated 11/17/2010. R20's care plan did not document new approaches or interventions for the falls on 3/3/13, 6/7/12 or 7/2/12. On 3/7/13 at 10:28 a.m. E3 verified the the interventions for falls should be on the Care Plan. The Facility's Fall Risk Pre Prevention and Monitoring Policy dated September 2007 documents "Care Planning the event on the care plan and adding interventions to the resident's care guide."	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow there policy on insulin administration for one of one resident (R17) reviewed for insulin administration in a sample of 19, and two residents (R27, R28) on	F 281		

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F 281	Continued From page 12 the supplemental sample. Findings include: 1. On 3-05-13 at 11:05 E4 was passing medications to residents. E4 performed blood glucose monitoring to R17 then prepared a syringe of insulin, drawing up an amount of insulin into the syringe based on the physician ' s order sheet (POS). E4 did not ask another nurse to verify the dose of insulin in the syringe intended for R17, nor did she verify with another nurse the type of insulin she was administering to R17 was correct based on R17 ' s POS. E4 proceeded to administer the insulin to R17. At 11:10a.m. E4 performed blood glucose monitoring to R27. E4 prepared a syringe of insulin for R27, drawing up an amount of insulin into the syringe based on R27 ' s physician ' s order sheet (POS). Again E4 did not ask another nurse to verify the dose of insulin in the syringe intended for R27, nor did she verify with another nurse the type of insulin she was administering to R27 was correct based on R27 ' s POS. 2. On 3-05-13 at 11:20a.m. E5 (Licensed Practical Nurse) was passing medications to residents. E4 performed blood glucose monitoring to R28 then prepared a syringe of insulin, drawing up an amount of insulin into the syringe based on R28 ' s physician ' s order sheet (POS). E5 stated that prior to administering R28 ' s insulin that she needed to verify that she had drawn up the correct amount and type of insulin by doing a " double check " with another nurse. E5 took the syringe full of insulin and the insulin bottle to E4 (Licensed Practical Nurse) so she could verify E5 was following the physician ' s orders correctly. E5 simply looked at the syringe and the insulin bottle and agreed that E5 had the correct amount and kind of insulin. E4 did not	F 281		

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F 281	Continued From page 13 verify the dosage or type of insulin by looking at R28 ' s physician ' s order sheet. A facility policy on medication administration dated 1-01-11 documents that, "All insulin orders must be verified with another nurse including syringe and insulin bottle prior (to) administration." On 3-06-13 at 11:00a.m. E2 (Director of Nurses) stated that the new insulin policy was implemented 1/2013 to prevent insulin administration errors from occurring. E2 stated that all nursing staff were given and in service on the new insulin policy which was added to the facility medication administration policy. A staff development in service record dated 1-15-13 to 1-17-13 documents that E4 and E5 (Licensed Practical Nurses) attended the in service on insulin administration which included a return demonstration by nursing staff. A document titled clinical procedure nursing practice manual from the University of Connecticut Health Center dated as revised 9/2012 documents that a high risk medication like insulin requires dosage verification by two nurses prior to administration to prevent medication errors.	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to implement new interventions after falls for five of 14 residents (R2, R6, R7, R18 and R22) reviewed for falls in the sample of 19. Findings include: Facility Fall Risk Prevention and Monitoring Policy dated September 2007 documents for staff to implement resident specific interventions to prevent further occurrences, care plan the event on the care plan and add interventions to the resident's care guide. R18's Fall Risk Assessments dated 12/12/12 and 12/27/12 document R18 is at high risk for falls. On 03/05/13 at 9:13 a.m., R18 was resting in bed with dark purple facial bruising from the forehead to the chin and a velcro knee immobilizer secured in place on the right knee. E3, ADON (Assistant Director of Nursing) stated, "(R18) fell last night." Facility's Incident Reports document R18 fell on 12/22/12 and 03/01/13. No interventions for these falls were documented on R18's current care plan dated 12/12/12. R18's current care plan dated 12/12/12 documents, "Resident is at risk for falls," and has no new approaches documented since 12/12/12. On 03/07/13 at 8:15 a.m., R18 was sitting in a wheelchair in the facility's secured unit's common	F 323		

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area. R18 had a large amount of bruising to the face and R18 was repositioning the right leg which had a velcro knee immobilizer fastened in place.

On 03/07/13 at 10:28 a.m., E3, ADON confirmed that R18's care plan had not been updated after R18 fell on 12/22/12 and 03/01/13 and stated, "They (new approaches for R18) should have been on the care plan."

R6's Fall Risk Assessments dated 09/04/12 and 12/20/12 document R6 is at high risk for falls.

On 03/05/13 at 1:31 p.m., R6 was sitting at a table in the facility's secured unit's common area. E9, CNA (Certified Nurse's Aide) sat a basket of laundry in front of R6. R6 began folding the laundry.

Facility Incident Reports document R6 fell on 10/06/12, 11/20/12, 01/26/13, and 02/15/13. No interventions for these falls were documented on R6's current care plan dated 09/04/12.

On 03/07/13 at 10:28 a.m., E3, ADON confirmed that R6's care plan had not been updated after R6 fell on 10/06/12, 11/20/12, 01/26/13, and 02/15/13 and stated, "They (new approaches for R6) should have been on the care plan."

R22's Fall Risk Assessments dated 09/12/12, 12/06/12, and 02/27/13 document R22 is at high risk for falls.

On 03/06/13 at 4:00 p.m., R22 was sitting in a wheelchair with a seatbelt fastened propelling down the hallway in the facility's locked unit.

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Facility Incident Reports document R22 fell on 10/14/12, 01/04/13, and 01/05/13. No interventions for these falls were documented on R22's current care plan dated 10/11/12.

On 03/07/13 at 10:28 a.m., E3, ADON confirmed that R22's care plan had not been updated after R22 fell on 10/14/12, 01/04/13, and 01/05/13 and stated, "They (new approaches for R22) should have been on the care plan."

R2's Fall Risk Assessments dated 04/25/12, 07/25/12, 10/25/12, and 01/10/13 document R2 is at high risk for falls.

On 03/07/13 at 8:07 a.m., R2 was sitting in a wheelchair in the common area of the facility's locked unit. R2 had a seatbelt secured with a seatbelt alarm in place. R2 was attempting to remove the seatbelt.

Facility Incident Reports document R2 fell on 05/24/12, 06/21/12, 09/11/12, 10/18/12, 10/29/12, 11/07/12, and 03/02/13. No interventions for these falls were documented on R2's current care plan dated 10/25/12.

On 03/07/13 at 10:28 a.m., E3, ADON confirmed that R2's care plan had not been updated after R2 fell on 05/24/12, 06/21/12, 09/11/12, 10/18/12, 10/29/12, 11/07/12, and 03/02/13 and stated, "They (new approaches for R2) should have been on the care plan."

R7's Fall Risk Assessments dated 04/17/12, 08/12/12, 11/01/12, and 01/05/13 document R7 is at high risk for falls.

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F 323	Continued From page 17 On 03/05/13 at 1:40 p.m., R7 was ambulating with a walker in the hallway of the facility's locked unit and sat down in a chair of the common area. Facility Incident Reports document R7 fell on 06/20/12 and 09/12/12. No interventions for these falls were documented on R7 ' s care plan dated 05/09/12. On 03/07/13 at 10:28 a.m., E3, ADON confirmed that R7's care plan had not been updated after R7 fell on 06/20/12 and 09/12/12 and stated, "They (new approaches for R7) should have been on the care plan."	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441		

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isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
A. Based on observation, interview, and record review the facility failed to follow their policy for hand hygiene during resident care and medication administration for two of 19 residents (R17, R19) reviewed for infection control in a sample of 19, and two residents (R27, R28) on the supplemental sample.
Findings include:
1. On 3-05-13 at 11:05a.m. E4 (Licensed Practical Nurse) was passing medications to residents. E4 prepared a syringe of insulin for R17 then administered the insulin to R17 ' s left upper arm without applying gloves prior to giving the injection.
2. On 3-05-13 at 11:10a.m. E4 prepared a syringe of insulin for R29. E4 administered the insulin to R29 without applying gloves prior to giving the injection.
3. On 3-05-13 at 1:10p.m. E7 and E8 (Certified

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Nurse Aides) were providing incontinence care to R19. E7 assisted R19 to turn to the right while E8 cleaned fecal material from R19 ' s buttocks and perineal area. Once E8 finished with R19 ' s incontinence care, E8 then assisted R19 to reposition in bed, touching R19 ' s bare skin on his arm as well as his clothing. E8 then applied a clean blanket over R19. E8 did not remove her soiled gloves prior to touching R19 or touching R19 ' s clothing and linens.
A facility medication administration policy dated 1-01-11 documents that staff should, " Use Standard Precautions as needed when giving medication ... " A facility policy for subcutaneous injections (insulin injections) dated as revised 1-07-13 documents that staff should, " put on gloves, " prior to giving an injection to a resident.
On 3-06-13 at 3:40p.m. E6 (Licensed Practical Nurse/Infection Control Coordinator) stated that, " Nurses should wear gloves to give injections and wash their hands after removed E6 stated that all nursing had attended an annual nursing competency which included staff giving return demonstrations of insulin injections.
A staff development in service record dated 1-15-13 to 1-17-13 documents that E4 (Licensed Practical Nurse) attended the in service which included a return demonstration for insulin injections.
B. Based on observation, interview, and record review the facility failed to follow their policy for disinfecting shared blood glucose monitoring equipment for one of one residents (R17) reviewed for blood glucose monitoring on a sample of 19 and one resident (R29) on the supplemental sample.
Findings include:
On 3-05-13 at 11:05a.m. E4 (Licensed Practical

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F 441	Continued From page 20 Nurse)performed blood glucose monitoring to R17 by puncturing the end of R17 ' s finger using a sharp lancet and applying blood to a test strip inserted into the blood glucose monitoring machine. After E4 finished with R17 she then entered R27 ' s room and performed the same blood glucose monitoring, using the same blood glucose monitoring machine, and without disinfecting that machine before reusing it on R27. After E4 finished monitoring R27 ' s blood glucose, she then returned the blood glucose monitoring machine to a drawer in E4 ' s medicine cart without using disinfectant on the machine. A facility policy for cleaning glucometers (blood glucose monitoring machine) dated as revised 1-07-13 documents that, " All glucometers will be cleaned after every use and in between each resident. " On 3-06-13 at 3:40p.m. E6 (Licensed Practical Nurse/ Infection Control Coordinator) stated that staff should, " wipe the glucometer down between each resident and let dry. "	F 441		