STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345555	A. Building B. Wing	12/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Raleigh at Crabtree Valley	3830 Blue Ridge Road Raleigh, NC 27612

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. 32394 Based on observations, staff interviews, and record review, the facility staff failed to disinfect a shared blood glucose meter (glucometer) between residents with an approved disinfectant wipe for 2 of 3 residents whose blood glucose levels were checked (Resident #36 and Resident #81). This occurred while there was a resident with known bloodborne pathogens in the facility. Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-approved disinfectant in accordance with the manufacturer's instructions for disinfection of the glucometer potentially exposes residents to the spread of blood borne infections. Immediate Jeopardy began on 12/13/23 when Nurse #1 was observed attempting to perform blood glucose testing for two residents on her assigned hall using a shared glucometer. Nurse #1 used a hand sanitizing wipe (intended to remove light soil and dirt from hands) to clean the shared glucometer between the two residents instead of using an EPA-approved disinfectant wipe to clean/disinfect the shared glucometer. Immediate Jeopardy was removed on 12/15/23 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training. The findings included: A review of the facility's policy entitled Obtaining a Fingerstick Glucose [Sugar] Level (not dated) included: Purpose: The purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level. --Preparation: 1. Assemble equipment and supplies needed. Equipment and Supplies: 2. Glucose meter (glucometer) with single use safety lancet (disposable); (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

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Single use alcohol swab; and 4. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed). --Steps in the Procedure: 5. Place the equipment on the bedside stand or overbed table. Arrange the supplies so that they can be easily reached. 6. Wash hands; Wear clean gloves. 7. If alcohol is used to clean the fingertip, allow it to dry completely because the alcohol may alter the reading. 8. Obtain a blood sample by using a new disposable safety lancet with each fingerstick. Place a drop of blood on the reagent strip. 9. If bleeding persists, apply a bandage. 10. Discard lancet into sharps container. 11. Remove gloves, discard appropriately. 12. Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. 13. Wash hands. The manufacturer's User Guide for the glucometer used at the facility included Important Safety Instructions. These instructions noted, in part, The meter should be disinfected after use on each patient. This blood glucose monitoring system may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed. The Cleaning and Disinfecting Procedures for the Meter read in part, The [Brand Name] meter should be cleaned and disinfected between each patient. A list of products approved for cleaning and disinfecting the glucometer was provided by the manufacturer. The glucometer's manufacturer also noted, Other EPA registered wipes may be used for disinfecting the [Brand Name] system, however, these wipes have not been validated and could affect the performance of your meter . (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Two types of disinfectant wipes were available for use at the facility to disinfect a shared glucometer: Disinfectant Wipe #1 was listed as an approved product by the manufacturer of the glucometer for cleaning/disinfecting the facility's (Brand Name) glucometer; Disinfectant Wipe #2 was not specifically listed as approved by the manufacturer of the glucometer for cleaning and disinfecting the facility's glucometers. However, Disinfectant Wipe #2 was also an EPA-registered product effective against human immunodeficiency virus (HIV-1), hepatitis B virus (HBV) and hepatitis C virus (HCV). The directions for use printed on the manufacturer's label of Disinfectant Wipe #2 read in part: This product kills the following viruses in 2 minutes on pre-cleaned hard, non-porous surfaces at room temperature when used as directed. Special instructions for cleaning and decontamination against HIV-1, HBV and HCV indicated, Contact Time: Allow hard, non-porous surfaces to remain wet for 2 minutes to kill HIV-1, HBV, and HCV. The facility provided a listing of the education topics provided to Nurse #1. A form signed by Nurse #1 and dated 10/4/23 acknowledged annual training was received on 26 topics. The topics included, in part: Fasting Blood Sugar Checks and Insulin; Infection Control; and Blood-Borne Pathogens. A portion of the educational material received by Nurse #1 read: Each Med [Medication] Cart should have 2 Blood Sugar Glucometers. Nurses should alternate using machines when doing Accuchecks [blood glucose checks]. Machines should be cleaned with Germicidal wipes (white top). Leave Open to air to dry, before next use. An observation was conducted on 12/13/23 at 11:55 AM as Nurse #1 collected supplies (a vial of test strips, a lancet, and an alcohol wipe) and obtained a glucometer from the medication cart in preparation to conduct a blood glucose check for Resident #36. The glucometer was not labeled with a resident's name. Nurse #1 was accompanied as she carried the glucometer and supplies down to Resident #36's room. After entering the room, the nurse put the glucometer and supplies down on a paper towel placed on the resident's bedside tray table. While wearing gloves, the nurse wiped the resident's finger with an alcohol pad, used a lancet to obtain a drop of blood from his finger and applied the blood to the test strip inserted into the glucometer. Once the blood glucose results were obtained, Nurse #1 discarded the trash and lancet, then returned to the medication cart with the glucometer. The nurse was observed as she pulled a (Brand Name) Hand Sanitizing Wipe from its container placed on top of the medication cart. She used this hand sanitizing wipe to wipe off the glucometer used to test Resident #36's blood glucose level. The nurse then collected supplies from the medication cart to check another resident's blood glucose and picked up the glucometer she had just wiped off with the hand sanitizing wipe. Nurse #1 was accompanied as she walked down the hall to do the blood glucose check for Resident #81. On 12/13/23 at 12:00 PM, the nurse reached the door of Resident #81's room. At that time, the nurse was asked to stop before entering the resident's room. The nurse was questioned as to whether the wipes used to clean the shared glucometer was an appropriate disinfectant wipe. She was asked to return to the medication cart. As Nurse #1 walked back to her medication cart located next to the nurses' station, the nurse reported she typically did not use the hand sanitizing wipes to clean a glucometer. Nurse #1 held up an alcohol wipe and stated she usually used an alcohol wipe to clean the glucometer between residents. The alcohol wipe held up by the nurse was an alcohol pad used to clean a resident's finger prior to drawing blood for the blood glucose check. At that time, the nurse was informed that an alcohol wipe was not an approved disinfectant for a glucometer. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Upon reaching the medication cart on 12/13/23 at 12:01 PM, Nurse #1 asked the Registered Nurse (RN) Supervisor what disinfectant wipes she should use to clean/disinfect the shared glucometer between residents. The RN Supervisor came over to the medication cart and was observed as she looked in the drawers of the medication cart to see if disinfectant wipes were on the medication cart. No disinfectant wipes were found on the medication cart. The RN Supervisor left the nurses' station to obtain approved disinfectant wipes for the glucometer. While she was gone, a container of Disinfectant Wipes #2 was located at the nurses' station. After reviewing the manufacturer's labeling and directions for use for Disinfectant Wipes #2, Nurse #1 used these wipes, per manufacturer's directions, to disinfect the shared glucometer. On 12/13/23 at 12:05 PM, an interview was conducted with Nurse #1. Upon inquiry, Nurse #1 reported she used this shared glucometer to check the blood glucose levels of residents on her assignment earlier that morning. These residents were identified by their electronic medical records (EMRs) as Resident #36, #81, #264, #70 and #90. When asked if she usually cleaned the glucometer before or after use with the alcohol wipes, the nurse stated both. Upon request as to where the shared glucometer was stored, the nurse opened the top drawer of the medication cart revealing a second glucometer placed in a plastic basket with a bottle of test strips. Nurse #1 reported both shared glucometers were stored in the basket on the medication cart when they were not in use. The nurse stated while the second glucometer also worked, she had only used the one shared glucometer earlier that morning to complete the blood glucose checks. A follow-up interview was conducted on 12/14/23 at 8:00 AM with Nurse #1. During the interview, the nurse was asked to confirm what she used to clean/disinfect the shared glucometer between residents when she checked their blood glucose levels on the morning of 12/13/23. Nurse #1 stated she used the wipes with the white top (referring to Disinfectant Wipes #2). At that time, Nurse #1 was reminded that while walking back to the medication cart after being stopped from checking Resident #81's blood glucose on 12/13/23, the nurse held up an alcohol wipe and stated she usually used an alcohol wipe to clean the shared glucometer between residents. The nurse then stated she, didn't mean those alcohol wipes. Nurse #1 added that she meant she used the germicidal wipes with the white top. When reminded there were no approved disinfectant wipes found on her medication cart, the nurse stated she used the disinfectant wipes at the nursing station on the morning of 12/13/23. The RN Supervisor returned to the medication cart at 12:10 PM with a second container of Disinfectant Wipes #2. At that time, the RN Supervisor confirmed Disinfectant Wipes #2 were the correct wipes for disinfecting the facility's glucometers. On 12/13/23 at 12:20 PM, the facility's Director of Nursing (DON) was informed of the concern related to the facility's failure to use an EPA-approved disinfectant to clean/disinfect a shared glucometer. During the interview, the DON was informed [Brand Name] Hand Sanitizing Wipes were observed to be used to clean a shared glucometer between residents, but the nurse was stopped during the observation (before the shared glucometer could be used for a second resident). The DON was also informed Nurse #1 reported she typically used an alcohol wipe (not an EPA-approved disinfection product) to clean/disinfect a shared glucometer. At that time, the DON stated the nursing staff had been educated on multiple occasions on the proper disinfection of glucometers and the appropriate disinfection product that needed to be used. She reported the facility had two appropriate products for glucometer disinfection (referring to Disinfectant Wipe #1 and Disinfectant Wipe #2). (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 12/13/23 at 2:10 PM with the facility's Administrator. During the interview, the Administrator reported she had been informed of the concern related to the failure of a nurse to use an EPA-approved disinfectant between residents for a shared glucometer. She stated the appropriate disinfectant wipes had been passed out after the concern related to glucometer disinfection was identified so the EPA-approved disinfectant wipes would be available on each medication cart for use. At that time, the Administrator was asked for a listing of residents in the facility who were diagnosed with a known blood borne pathogen. A review of the EMR and medical diagnoses for current residents at the facility was conducted. One resident was identified as having diagnoses which included two blood borne pathogens (HIV and acute hepatitis B). The facility's Administrator and DON were informed of the immediate jeopardy on 12/13/23 at 2:20 PM. The facility provided the following plan for IJ removal. Credible Allegation of Compliance Demonstrating Removal of Immediate Jeopardy ---Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. -It was determined that the brand named hand-sanitizing wipes were on one medication cart on December 13, 2023. -Prior to December 13, 2023, the only glucometer cleaning wipes on the medication cart were manufacturer's approved equipment germicidal wipes. -It was determined based on investigation by the DON and her designee that Nurse #1 had only used the brand named hand-sanitizing wipes to clean the glucometer before using the glucometer for Resident #36. -Nurse #1 only was assigned to conduct blood glucose checks on 5 residents (#36, #81, #264, #70 and # 90) on December 13, 2023. -However, Nurse #1 who conducted the observed blood glucose checks reported to the surveyor that she normally used an alcohol wipe to clean the shared glucometer. The alcohol pad that is used to clean a resident's finger before blood is drawn, is not a manufacturer approved equipment germicidal wipe. -Any of the 5 residents for whom Nurse #1 was assigned to conduct a blood glucose check could have been impacted by the alleged non-compliance. -The medical records for the 5 residents were reviewed by the DON and her designee on December 13, 2023. (On December 13, 2023, there were 21 residents in the entire facility who required blood glucose checks.) No other nurses had the brand named hand-sanitizing wipes on their cart, all other nurses were observed with the correct germicidal wipes on their cart. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-It was determined that none of the 5 residents who could have been checked by Nurse #1 had a diagnosis of a blood-borne pathogen. The resident referenced in the immediate jeopardy template as having a blood-borne pathogen did not receive blood glucose checks. ---Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. -All 6 medication carts were checked on December 13, 2023, by DON or designee. No other medication cart was found with the brand named hand-sanitizing wipes. -DON or designee determined on December 13, 2023, that all the medication carts had manufacturer recommended germicidal wipes for cleaning the glucometer. The medication cart used by Nurse #1 did not have the recommended germicidal wipes on her cart. The DON did confirm with Nurse #1 that the germicidal wipes were within her reach at all times. -On December 13, 2023, the brand named hand-sanitizing wipes were removed from use in the facility by DON or designee. -On December 13, 2023 in-service began by DON for all nurses and med aides, including Agency staff, pertaining to use of the glucometer and cleaning the glucometer with a germicidal EPA registered disinfectant wipe. -All nurses and medication aides will be in-serviced prior to the start of their shift -No nurse or medication aide will be permitted to perform blood glucose checks or use a glucometer until they have been in-serviced. -Starting December 13, 2023 DON or her designee will monitor staff to ensure compliance until shift supervisors are trained regarding in-services and monitoring. Once trained, shift supervisors will monitor and train staff (to include agency staff) prior to their shift. -On December 13, 2023, DON notified Wake County Health department, regarding the use of brand named hand-sanitizing wipes to clean a glucometer. -On December 14, 2023, DON or designee notified Wake County Health department, regarding the potential use of an alcohol based wipe rather than a manufacturer's approved equipment germicidal wipes to clean a glucometer -On December 13, 2023, DON notified Resident #36 and their responsible parties regarding the use of brand named hand-sanitizing wipes to clean a glucometer. -On December 14, 2023, DON or her designee notified Residents #81, #264, #70 and # 90 and all 5 resident's responsible parties of the potential use of an alcohol based wipe rather than a manufacturer's approved equipment germicidal wipes to clean a glucometer. -On December 13, 2023, DON notified the physician for Resident #36 regarding the use of brand named hand-sanitizing wipes to clean a glucometer. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On December 14, 2023, DON or her designee notified the physician for Residents #81, #264, #70 and # 90 of the potential use of an alcohol based wipe rather than a manufacturer's approved equipment germicidal wipes to clean a glucometer -Physician ordered monitoring of Resident #36 for signs and symptoms of adverse reactions. The immediate jeopardy was removed on 12/15/23. The facility's credible allegation of immediate jeopardy removal was validated on 12/15/23. Documentation of the County Health Department, physician, and residents' Responsible Party notification was provided and reviewed. The validation was also evidenced by nurse observations and interviews conducted on each hallway with regards to the required infection control practices for the use of shared glucometers. All nurses who were interviewed reported they had received the required in-service training. This training included the importance of using an approved disinfectant wipe and disinfecting a shared glucometer with the proper procedures in accordance with the manufacturer's instructions for the disinfectant. Observations were conducted on each hallway as blood glucose checks were conducted and glucometers were disinfected. Multiple observations also confirmed EPA-approved disinfectant wipes were stored on each medication cart and containers of the [Brand Name] Hand Sanitizing Wipes were no longer observed on the halls or medication carts. The credible allegation was validated, and the immediate jeopardy was removed on 12/15/23.