STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910406	**02/27/2019**
NAME OF PROVIDER OR SUPPLIER **CRESTVIEW MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **603 NORTH PEARL STREET** **CRESTVIEW, FL 32536**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced complaint investigation (CCR# 2018018665) was conducted at Crestview Manor on - 27/2019. Deficient practice was identified at the time of the survey.

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observation, interview and record review the facility failed to follow basic principles of control. This was evidenced by the facility staff failure to ensure safe control practices were followed while assisting 6 of 9 sampled residents (Residents #1-#2, #7, #15-17) that perform self -testing of and self-administration of .

The findings included:

On staring at approximately 3:45 PM, multiple medication observations were made of 6 residents who were assessed to require assistance with self -administration of medications. The residents were identified by the facility to be capable of conducting self- testing of their levels and self- administration of their prescribed .

1. Resident #7 was observed at 3:45 PM to enter the medication room and staff A opened a medication cart and removed the resident's stored in a small black case from the cart where other resident medications were stored and handed the case directly to the resident for use. The resident was observed to prick her with a lancet and she performed her own testing. The resident wiped her bloody on a cotton ball and then placed the into the case, and handed it to staff A. Staff A was observed without gloves/bare handed, she took the case from the resident and immediately placed it into the facility medication cart for storage. Staff A was not observed to wipe the unit or case prior to returning it to the clean medication storage cart.

2. Resident #15 was observed at 3:55 PM to enter the medication room and staff A opened a medication cart and removed the resident's stored in a small black case from the cart where other resident medications were stored and handed the case directly to the resident for use. Resident #15 was observed to prick his with a lancet and she performed his own testing. The resident wiped his bloody on his pants and then placed the into the case, and handed it to staff A. Staff A was observed without gloves /bare handed, she took the case from the resident and immediately place it into the facility medication cart for storage. Staff A was not observed to wipe the unit or case prior to returning it to the clean medication storage cart.

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3. Resident #16 was observed at 4:05PM PM to enter the medication room and staff A opened a medication cart and removed the resident's ⌄ stored in a small black case from the cart where other resident medications were stored and handed the case directly to the resident for use. Resident #16 was observed to prick her ⌄ with a lancet and she performed her own ⌄ testing. The resident wiped her bloody ⌄ on a tissue and then placed the ⌄ into the case, and handed it to staff A. Staff A was observed without gloves /bare handed, she took the case from the resident and immediately place it into the facility medication cart for storage. Staff A was not observed to wipe the ⌄ unit or case prior to returning it to the clean medication storage cart.

4. Resident #2 was observed at 4:10 PM PM to enter the medication room and staff A opened a medication cart and removed the resident's ⌄ stored in a small black case from the cart where other resident medications were stored and handed the case directly to the resident for use. The resident was observed to prick his ⌄ with a lancet and he performed his own ⌄ testing. The resident wiped his bloody ⌄ on his and with bloody , he placed the ⌄ into the case, and handed it to staff A. Staff A was observed without gloves /bare handed, she took the case from the resident and immediately place it into the facility medication cart for storage. Staff A was not observed to wipe the ⌄ unit or case prior to returning it to the clean medication storage cart. In an observation at 2:59 PM on , Resident 2's ⌄ case and unit was observed to be soiled with dried over the unit and inside of the case. (See photographic evidence.)

5. Resident #17 was observed at 4:11 PM PM to enter the medication room and staff A opened a medication cart and removed the resident's ⌄ stored in a small black case from the cart where other resident medications were stored and handed the case directly to the resident for use. The resident was observed to prick her ⌄ with a lancet and performed her own ⌄ testing. The resident wiped her ⌄ on a cotton ball and placed the ⌄ into the case, and handed it to staff A. Staff A was observed bare handed, she took the case from the resident and immediately place it into the facility medication cart for storage. Staff A was not observed to wipe the ⌄ unit or case prior to returning it to the clean medication storage cart.

6. Resident #12 was observed at 4:13PM PM to enter the medication room and staff A opened a medication cart and removed the resident's ⌄ stored in a small black case from the cart where other resident medications were stored and handed the case directly to the resident for use. Resident #12 was observed to prick his ⌄ with a lancet and performed his own ⌄ testing. The resident was observed to place his ⌄ ⌄ into his , sucking off the and then using the same he placed the ⌄ into the case, and handed it to staff A. Staff A was observed without gloves /bare handed, she took the case from the resident and immediately place it into the facility medication cart for storage. Staff A was not observed to wipe the ⌄ unit or case

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prior to returning it to the clean medication storage cart.

7. In an additional observation on at approximately 2:50PM Resident # 1's / case was observed to be stored in the medication cart along with medications for other residents. Staff A removed the case from the drawer with her bare , and opened the case. The unit and inside of the case was observed soiled with dried . (see photographic evidence). In an interview with staff A, she stated that Resident #1 performed his own testing and administration and he was not careful to keep his clean. She stated that she did not clean the or the storage cases for the residents and she only handed the case to the resident since " they performed their own testing and administration of ". She stated that she had attended additional training which covered the topic of assisting the resident with self -administration of and but she could not recall any specific instructions regarding best practices for preventing bloodbourne , transmission during monitoring and administration. She stated that she used sanitizer after she touched the outside of the cases. She stated that she was not sure of the facility policy regarding control and . Review of staff A personnel file revealed she had attended training class for unlicensed staff assistance with self-administration 2 hour update class on .

Review of the facility's "Standard Precautions" policy and procedure revealed "standard precautions were a set of control practices used to prevent transmission of that can be acquired by contact with , , non-intact skin and ." Review of the policy indicated that hygiene should be performed before and after contact with a resident, and immediately after touching , or contaminated items or medical equipment used for resident care.

Review of the "Centers for Control and Prevention" (CDC) website indicated that "the CDC has become increasingly concerned about the risks for transmitting ( ) and other during assisted ( ) monitoring and administration." Further review of the website recommended practices for preventing bloodbourne , transmission revealed " unused supplies and medications should be maintained in a clean area, separate from used supplies and equipment (e.g. meters)." Additional recommended practices included hygiene and wearing gloves during any potential exposure to or , and changing gloves between patients and when gloves have touched potentially contaminated objects. Also performing hygiene immediately after removal of gloves and before touching other medical supplies intended for use on other persons.

During an interview with the Manager on at 4:30PM, she stated that she had completed the 2-hour update training in which included instruction on assisting residents with self- administration

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of and testing via . She stated that approximately 9 residents, who were identified to require staff assistance with self- administration of medications, have been allowed to self -administer their own and perform testing. She stated that the facility staff do not assist the residents with those tasks, and the staff only centrally store the resident's medication ( ) in the refrigerator and in the medication carts. She was questioned about cleaning the if they were observed soiled and she stated that she would need to discuss the policy with her management team. When she was asked to observed Residents # 1 and #2's soiled stored inside the medication carts, she stated that the residents do not routinely clean their , and the residents simply the /case to the staff for storage in the medication cart. When asked about the facility policy for storing potentially contaminated equipment along with medications, she stated that she had no explanation. She stated that she would clean soiled equipment by wiping the units with or a soapy damp cloth to remove the dried . She stated that she had no products available at that time and had no specific cleaning instructions from the manufacturer. The Manager stated that she agreed that the storage of the soiled cases and inside the facility medications carts was not the best practice for the prevention of bloodbourne transmission and staff should be using proper hygiene when exposed to possible contaminated equipment.

Class III