STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08G013	A. BUILDING _____ B. WING _____	C 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY CAMPBELL CENTER	4641 WELDIN RD WILMINGTON, DE 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from January 27, 2020 through January 30, 2020. The facility census the first day of the survey was 68. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were cited.	E 000		
W 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from January 27, 2020 through January 30, 2020. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 68 The sample size totaled twelve residents. Abbreviations/definitions used in this report are as follows: AED - Assistant Executive Director; ADON - Assistant Director of Nursing; ED - Executive Director; CM - Case Manager; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA- Nursing Home Administrator; NM - Nurse Manager; RN - Registered Nurse; RCT - Resident Care Technician;	W 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anne M Studd | TITLE: Assistant Executive Director | (X6) DATE: 2/28/20

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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W 000	Continued From page 1 SLP - Speech Language Pathologist; QIDP - Qualified Intellectual Disabilities Professional; Comprehensive Functional Assessment - An assessment involving resident and all professions involved in their care and services; Humalog quick pen - a type of insulin; Insulin - injected medication to control blood sugar.	W 000		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, record review, interview, and other facility documentation as indicated, it was determined that for two (R5 and R1) out of 12 sampled residents reviewed, the facility failed to provide nursing services in accordance with their needs. For R5 the facility failed to maintain the resident safe from injury and for R1, the facility failed to ensure oral care was provided after eating as ordered. Findings include: 1. A facility policy entitled Resident Transfer and Repositioning dated 5/22/14 includes the following: 1. All residents are assessed by Physical Therapy for safety and best practice in present transfer...ability. 2. Physical Therapy provides recommendations based on assessment findings which then become transfer...requirements, as part of the residents care plan.	W 331	**W331, #1: Resident Transfer** **SECTION A** **(Individual Impacted)** As evidenced in the findings, the facility failed to prevent injury to resident R5. Care plan was updated at the time of the resident incident in August 2019 to reflect the appropriate sequence of removing safety belts. Electronic Health Record was also updated to communicate and provide instructions to staff providing care on the appropriate sequence to remove seatbelt. Staff member (E8) was immediately educated regarding seatbelt safety and ensuring resident safety and provided return demonstration of the proper sequence of belt release.	

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W 331	Continued From page 2 Review of R5's clinical record revealed the following: 10/8/18 - A Comprehensive Functional Assessment was completed. The Physical Therapy section documented that R5 was totally dependent needing two people to assist, for transfer to/from chair and needed the help of a mechanical lift. 8/20/19 - A facility accident report documented that R5 was sent to the emergency department for evaluation after falling forward out of R5's wheelchair, "while preparing for transfer." 8/20/19 - A witness statement completed by E8 (RCT) documented that E8 (RCT) unbuckled R5, while E9 (RCT) got the lift. 8/20/19 - A witness statement completed by E9 (RCT) documented that R5's "tech was unstrapping [R5's] feet and [R5]...fell out of the chair." 8/21/19 3:37 AM - A progress noted documented that R5 returned from the emergency department with three sutures on R5's chin. 8/21/19 - Documentation of a phone interview with E8 (RCT) documented that "while I was unbuckling her feet rest, she...fell to the side from her chair." 8/21/19 - Documentation of a phone interview with E9 (RCT) documented that "as [E9] went to get the lift, [E9] was releasing [R5's] harness, thigh straps, and feet straps. [R5] jerked forward and fell from the chair."	W 331	**SECTION A *(Cont.)*** Seatbelt safety and release protocol training was conducted from September 11, 2019 through September 25, 2019. Corrective actions noted above completed by Staff Educator and Director of Nursing. **SECTION B** **(Identification of other residents)** Any Resident using a wheelchair safety belt could be affected by this practice. Care plans were reviewed to identify current residents utilizing wheelchair safety belts (Attachment C). Seatbelt safety and release protocol training was conducted from September 11, 2019 through September 25, 2019.	

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W 331	Continued From page 3 8/21/19 - A care plan intervention created for "When removing from wheelchair, release straps, belts, and harness starting from [R5's] lower extremities and finishing at [R5's] upper extremity/torso leaving the waist/seat belt last." 8/22/19 - Training documentation documented that E3 (Staff Educator) provided verbal education to E8 (RCT) "regarding seat belt safety and ensuring resident safety." E8 demonstrated "starting (unstrapping) from the lower (straps/belts) and leaving waist belt last prior to transfer." 8/27/19 - The facility's follow up report documented that the root cause analysis was the "RCT releasing [R5's] seatbelt too early prior to a transfer." The facility's investigative team found that E8 (RCT) unbuckled R5's ankle huggers after unbuckling the other straps, and at the same time that E9 (RCT) was getting the lift. 1/30/19 11:35 AM - During an interview E3 (Staff Educator) provided training documentation for Seatbelt Safety and Release Protocol training conducted, for all staff, between 9/11/19 and 9/25/19. This was the first time this training took place. E3 explained that there is no actual facility policy on this protocol as it is a standard of care. E3 explained that the particular steps of starting to unbuckle the lower extremities first and moving up, leaving the waist seatbelt for last, when unbuckling a resident from their wheelchair, was not always education provided by the facility to nursing staff, but after the incident it is now provided to all nursing staff. Competencies are completed on RCTs, but the order of unbuckling seatbelts during transfer was not part of the	W 331	**SECTION C** **(System Changes)** RCT(E8) released resident waist belt too early prior to lift transfer. To prevent re-occurrence care plans were reviewed by Nurse Managers to identify current residents utilizing wheelchair safety belts. CNA instructions in the Electronic Health Record will be updated to included seat belt safety and release protocol. Seatbelt safety and release protocol training conducted in September 2019 by Staff Educator. Mechanical lift transfer policy and procedure was created by Director of Nursing to reflect current transfer practice. (Attachment G) Staff will be trained on the new policy by 3/30/20.	

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W 331	Continued From page 4 competencies until after this incident. 1/30/19 12:20 PM - During interviews, E10 (RCT) and E11 (RCT) confirmed that the sling of the lift is to be hooked before the resident's buckles are released. 2/3/19 - A statement from E14 (PT) revealed that not only did transferring R5 require that R5's seatbelt be released last, but the seatbelt should not be removed until other supports are in place and a second person in present to assist. There was no evidence that the facility included physical therapy recommendations for safety in transferring R5 as part of R5's care plan, prior to this incident. The facility failed to properly prepare for the activity of transferring R5. This resulted in R5 falling and sustaining an injury to the chin requiring sutures. 2. Review of R1's medical record revealed the following: 11/29/19 - R1 was admitted to the facility with diagnoses including dysphagia. 1/3/20 - A Physician's order for dysphagia 1 diet (puree consistency) included that R1 may be offered up to 4 ounces of whipped peanut butter or chocolate pudding twice a day. The order included the following positioning and feeding assistance guidelines: - Wheelchair may be slightly reclined. - Head support pillow and Hensinger (support) collar in place. - Assist from right side and provide physical	W 331	**SECTION D** **(Success Evaluation)** An audit tool has been developed (Attachment D) to assess compliance with seatbelt safety and release protocol. Audits will be completed by Nurse Manager or designee in each neighborhood once weekly x 4 weeks until 100% compliance is met, and then once monthly for two months or until 100% compliance is met. **W331, #2: Oral Care** **SECTION A** **(Individual Impacted)** As was evidenced in the findings, it was determined that resident R1 did not receive oral care immediately after eating as ordered. Care plan was immediately updated to reflect oral care after eating. Physician order was clarified to provide oral care immediately after eating. Electronic Health Record was updated to require that staff document oral care after eating. No additional residents were impacted by the practice. Corrective actions noted above were completed by Director of Nursing.	3/30/20

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W 331	Continued From page 5 support to keep head more midline. - Offer teaspoon using brown spoon, wait for swallow before giving more and present empty spoon to encourage a second swallow to fully clear oral cavity. - Provide oral care removing any excess food with a toothette when R1 was finished eating. - Discontinue snack if R1 was consistently coughing or not fully engaged in eating. 1/29/20 12:09 PM to 12:24 PM - During a random lunch observation, beginning at 12:09 AM, E12 (RCT), after implementation of the prescribed positioning and feeding assistance guidelines, began feeding R1 the whipped peanut butter. At 12:24 PM, feeding was completed and R1's Hensiger collar was removed and R1 was transported to a different location in the unit where the TV was located. E12 proceeded to return to the table and sat, where two other staff members were assisting two other residents with their meals. 1/29/20 12:26 PM - The surveyor interviewed E12 (RCT) and inquired when R1's oral care would be provided to remove any excess food using the toothette. E12 replied that once the two remaining residents at the table were finished. 1/29/20 12:27 PM - The surveyor observed R1 being transported to his room for oral care. 1/29/20 2:02 PM - An interview with E13 (SLP) revealed that due to R1's high palate, oral care after R1's feeding must be completed to remove excess food to prevent chocking or aspiration. E13 verbalized that the oral care must be completed immediately after eating.	W 331	**SECTION B** **(Identification of other residents)** Physicians orders were reviewed to identify any residents with orders to "clean mouth out with toothette after eating." (Attachment A) No additional residents were identified as being affected by this practice. **SECTION C** **(System Changes)** Although oral care was provided within five minutes upon completion of resident's meal, the care did not occur "immediately." R1's meal ticket has been updated to clarify that oral care with toothette be provided immediately after resident is finished eating. Physician's order and meal tickets were changed to reflect the need for oral care after meals. Electronic Health Record updated to ensure staff is aware of the need for immediate oral care after eating. Staff will be re-educated by the Staff Educator or designee to follow the instructions provided on meal tickets by 3/30/2020.	

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W 331	Continued From page 6 1/29/20 3:00 PM - The surveyor reviewed the above observation with E2 (DON) in which R1 had completed his feeding at 12:24 PM and R1 was not provided oral care to remove excess food after R1 finished eating. E2 verbalized that there may be a need to clarify the order to indicate when to complete the oral care. The surveyor informed E2 that an interview with E13 (SLP) was conducted which revealed that the oral care should be provided after R1 was finished eating to prevent chocking or aspiration. 1/29/20 3:10 PM - The surveyor reviewed the above observation with E1 (AED) in the presence of E2 (DON). 1/30/20 4:10 PM - The findings reviewed during the Exit Meeting with E1 (AED) and E2 (DON).	W 331	**SECTION D** **(Success Evaluation)** An audit tool has been developed (Attachment B) to assess compliance with meal tickets instructions. Audits will be completed by Nurse Manager or designee once weekly x 4 weeks until 100% compliance is met, and then once monthly for two months or until 100% compliance is met.	3/30/20
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation, interview and review of facility documentation it was determined that the facility failed to ensure proper infection control techniques during medication administration for three (R9, R10, and R11) out of five sampled residents. 1. During an observation on 1/28/20 at 1:30 PM, E5 (LPN) put on gloves to administer eye drops to R9. After picking up the bottle of eye drops and tissues with the right hand, E5 then put the eye drops and tissues in left hand to reach up with	W 454	**W454** **SECTION A** **(Individual Impacted)** As evidenced in the findings, it was determined that two staff (E5 and E7) failed to avoid contaminating clean gloves during administration of ophthalmic drops. Staff member E6 did not maintain aseptic technique, or follow manufacturer's instructions to prime a Humalog KwikPen, prior to administration. Upon written notification of the deficient practice, the Staff Educator or designee will remind nursing staff to avoid contamination of clean gloves and manufacturer's instructions on preparing insulin pens.	

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W 454	Continued From page 7 right hand to touch the computer screen. E5 then put the eye drops in the right hand to administer the drops. E5 touched the computer screen with gloved hands and then immediately proceeded to administer eye drops without washing hands or changing gloves. 2. During an observation on 1/29/20 at 12:20 PM, E6 (LPN) prepared an insulin pen for R10 to self-administer. E6 did not wipe the rubber tip with alcohol before placing the needle on the pen. Also, E6 did not prime the Humalog quick pen the required 2 units prior to R10 dialing up the prescribed amount of insulin. According to the manufacturer's instructions for the Humalog quick pen the rubber tip is to be wiped with alcohol and primed with two units of insulin prior to each administration. 3. During an observation on 1/29/20 at 1:14 PM, E7 (LPN) put on gloves and picked up a bottle of eye drops and tissues in the left hand. E7 then transferred the eye drops from the left hand to the right hand to administer to R11. R11 reminded E7 to turn off the wheelchair before administering the eye drops. E7 transferred the eye drops back to the left hand and reached up with right hand to turn the wheelchair off. E7 then transferred the eye drops from the left hand to the right hand and administered the eye drops. E7 touched the switch on the wheelchair with a gloved hand then immediately proceeded to administer eye drops. During an interview on 1/30/20 at 11:40 AM, E3 (Staff Educator) agreed that administering eye drops after touching other objects with the same gloves is not a proper infection control technique. E3 further revealed that appropriate procedure for preparing an insulin pen is to wipe the rubber tip	W 454	**SECTION A *(Continued)*** Any resident who receives ophthalmic drops or insulin via pen may be impacted by these practices. **SECTION B** **(Identification of other residents)** Physicians orders were reviewed to identify residents with orders for ophthalmic drops or insulin via pen. **SECTION C** **(System Changes)** Nurses did not avoid contaminating clean gloves during administration of ophthalmic drops and failed to use proper technique to administer insulin. A lesson plan will be developed by the Staff Educator and nurses will receive training on aseptic technique and manufacturer's instructions on preparing insulin pens by 3/30/2020. Any nurse identified as not using proper glove technique during ophthalmic drop or following manufacturer's instruction to wipe and prime insulin pen will be re-educated by nursing administration or designee. Pharmacy vendor Medication Administration Procedure was reviewed, and no revisions are necessary.	

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W 454	Continued From page 8 with alcohol and prime the pen with 2 units of insulin. These findings were reviewed with E1 (EA), E2 (DON), and E3 (Staff Educator) during the exit conference beginning at approximately 4:10 PM on 1/30/20.	W 454	**SECTION D** **(Success Evaluation)** An audit tool has been developed (Attachment E) to assess compliance with avoiding contamination of clean gloves during administration of ophthalmic drops and an audit tool for correct preparation of insulin pen (Attachment F). Nurse managers or designees will perform weekly audits for four weeks until 100% compliance is met, and then once monthly for two months or until	3/30/20

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Mary Campbell Center

DATE SURVEY COMPLETED: January 30, 2020

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal report. An unannounced annual and complaint survey was conducted at this facility from January 27, 2020 through January 30,2020. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 68 The sample size totaled twelve residents. During this period, an Emergency Preparedness survey was also conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection. For the Emergency Preparedness survey, no deficiencies were cited. Abbreviations/definitions used in this report are as follows: AED - Assistant Executive Director; ADON - Assistant Director of Nursing; ED - Executive Director; CM - Case Manager; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA- Nursing Home Administrator; NM - Nurse Manager; RN - Registered Nurse; RCT - Resident Care Technician; SLP - Speech Language Pathologist; QIDP - Qualified Intellectual Disabilities Professional;		

Provider's Signature Ann M Shedd Title Assistant Executive Director Date 2/28/20

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NAME OF FACILITY: Mary Campbell Center

DATE SURVEY COMPLETED: January 30, 2020

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
3201 **3201.1.0** **3201.1.2**	Comprehensive Functional Assessment - An assessment involving resident and all professions involved in their care and services; Humalog quick pen - a type of insulin; Insulin - injected medication to control blood sugar; **Regulations for Skilled and Intermediate Care Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements.** **This requirement is not met as evidenced by:** Cross reference to the CMS 2567-L survey report completed on January 30, 2020: W331 and W454.	***State 3201.1.2— Cross Reference with Federal Tag W331, #1: Resident Transfer*** **SECTION A (Individual Impacted)** As evidenced in the findings, the facility failed to prevent injury to resident R5. Care plan was updated at the time of the resident incident in August 2019 to reflect the appropriate sequence of removing safety belts. Electronic Health Record was also updated to communicate and provide instructions to staff providing care on the appropriate sequence to remove seatbelt. Staff member (E8) was immediately educated regarding seatbelt safety and ensuring resident safety and provided return demonstration of the proper sequence of belt release. Seatbelt safety and release protocol training was conducted from September 11, 2019 through September 25, 2019. Corrective actions noted above completed by Staff Educator and Director of Nursing. **SECTION B (Identification of other residents)** Any Resident using a wheelchair safety belt could be affected by this practice. Care plans were reviewed to identify current residents utilizing wheelchair safety belts (Attachment C). Seatbelt safety and release protocol training was conducted from September 11, 2019 through September 25, 2019.	

Provider's Signature Anne M Judd Title Asst Executive Director Date 2/28/20

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NAME OF FACILITY: Mary Campbell Center **DATE SURVEY COMPLETED: January 30, 2020**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
		SECTION C (System Changes) RCT(E8) released resident waist belt too early prior to lift transfer. To prevent reoccurrence care plans were reviewed by Nurse Managers to identify current residents utilizing wheelchair safety belts. CNA instructions in the Electronic Health Record will be updated to included seat belt safety and release protocol. Seatbelt safety and release protocol training conducted in September 2019 by Staff Educator. Mechanical lift transfer policy and procedure was created by Director of Nursing to reflect current transfer practice. (Attachment G) Staff will be trained on new policy by 3/30/20. **SECTION D (Success Evaluation)** An audit tool has been developed (Attachment D) to assess compliance with seatbelt safety and release protocol. Audits will be completed by Nurse Manager or designee in each neighborhood once weekly x 4 weeks until 100% compliance is met, and then once monthly for two months or until 100% compliance is met. ***State 3201.1.2— Cross Reference with Federal Tag W331, #2: Oral Care*** **SECTION A (Individual Impacted)** As was evidenced in the findings, it was determined that resident R1 did not receive oral care immediately after eating as ordered. Care plan was immediately updated to reflect oral care after eating. Physician order was clarified to provide oral care immediately after eating.	***3/30/20***

Provider's Signature Ann M Stidd Title Asst Executive Director Date 2/28/20.

NAME OF FACILITY: Mary Campbell Center

DATE SURVEY COMPLETED: January 30, 2020

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
		SECTION A, Cont. Electronic Health Record was updated to require that staff document oral care after eating. No additional residents were impacted by the practice. Corrective actions noted above were completed by Director of Nursing. **SECTION B (Identification of other residents)** Physicians orders were reviewed to identify any residents with orders to "clean mouth out with toothette after eating." (Attachment A) No additional residents were identified as being affected by this practice. **SECTION C (System Changes)** Although oral care was provided within five minutes upon completion of resident's meal, the care did not occur "immediately." R1's meal ticket has been updated to clarify that oral care with toothette be provided immediately after resident is finished eating. Physician's order and meal tickets were changed to reflect the need for oral care after meals. Electronic Health Record updated to ensure staff is aware of the need for immediate oral care after eating. Staff will be re-educated by the Staff Educator or designee to follow the instructions provided on meal tickets by 3/30/2020. **SECTION D (Success Evaluation)** An audit tool has been developed (Attachment B) to assess compliance with meal tickets instructions. Audits will be completed by Nurse	

Provider's Signature Anne Judd Title Asst Executive Director Date 2/28/20

NAME OF FACILITY: Mary Campbell Center

DATE SURVEY COMPLETED: January 30, 2020

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
		SECTION D, *Cont.* Manager or designee once weekly x 4 weeks until 100% compliance is met, and then once monthly for two months or until 100% compliance is met. ***State 3201.1.2—*** ***Cross Reference with Federal Tag W454*** **SECTION A (Individual Impacted)** As evidenced in the findings, it was determined that two staff (E5 and E7) failed to avoid contaminating clean gloves during administration of ophthalmic drops. Staff member E6 did not maintain aseptic technique, or follow manufacturer's instructions to prime a Humalog KwikPen, prior to administration. Upon written notification of the deficient practice, the Staff Educator or designee will remind nursing staff to avoid contamination of clean gloves and manufacturer's instructions on preparing insulin pens. Any resident who receives ophthalmic drops or insulin via pen may be impacted by these practices. **SECTION B (Identification of other residents)** Physicians orders were reviewed to identify residents with orders for ophthalmic drops or insulin via pen. **SECTION C (System Changes)** Nurses did not avoid contaminating clean gloves during administration of ophthalmic drops and failed to	***3/30/20***

Provider's Signature Dawn Stidd Title Asst Executive Director Date 2/28/20

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
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STATE SURVEY REPORT

NAME OF FACILITY: Mary Campbell Center

DATE SURVEY COMPLETED: January 30, 2020

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTIONOF DEFICIENCIES	COMPLETION DATE
		SECTION C, *Cont.* use proper technique to administer insulin. A lesson plan will be developed by the Staff Educator and nurses will receive training on aseptic technique and manufacturer's instructions on preparing insulin pens by 3/30/2020. Any nurse identified as not using proper glove technique during ophthalmic drop or following manufacturer's instruction to wipe and prime insulin pen will be re-educated by nursing administration or designee. Pharmacy vendor Medication Administration Procedure was reviewed, and no revisions are necessary. **SECTION D (Success Evaluation)** An audit tool has been developed (Attachment E) to assess compliance with avoiding contamination of clean gloves during administration of ophthalmic drops and an audit tool for correct preparation of insulin pen (Attachment F). Nurse managers or designees will perform weekly audits for four weeks until 100 % compliance is met, and then once monthly for two months or until 100% compliance is met.	***3/30/20***

Provider's Signature Anne Judd Title Asst Executive Director Date 2/28/20