Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	B03806	10/14/2019
Name of Provider or Supplier	**Street Address, City, State**	
Benton Rural Health Clinic	543 Powell Ln, Benton, KY	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
J0042	PHYSICAL PLANT AND ENVIRONMENT 491.6(b) Maintenance: The clinic . . . has a preventive maintenance program to ensure that: (1) All essential mechanical, electrical and patient-care equipment is maintained in safe operating condition; This STANDARD is not met as evidenced by: Based on direct observation, staff interview, and record review, it was determined the facility failed to ensure blood glucose testing equipment was correctly tested for accuracy as part of its preventative maintenance program. The findings include: Review of the facility policy and procedure manual revealed the facility had policies and procedures for a different brand of glucometer rather than the one used by the facility. During a tour of the facility on 10/14/19 beginning at 10:10 AM it was noted the facility was using a brand of glucometer named the "Evencare G3" to test patient blood glucose levels. The facility produced a log that documented daily testing for the accuracy of the glucometer. The low range documented on the test strips identified an acceptable range of 37 - 67. However, further review of the log revealed it was documented on ten (10) of ten (10) occasions, the testing results were lower than the acceptable range from 09/30/19 to 10/10/19. In addition, there was no documented evidence corrective action was taken by the facility. Interview with Registered Nurse #1 (RN) about the lower than acceptable range readings on 10/14/19 at 1:37 PM revealed the RN did not understand the results of the readings obtained when obtaining quality controls for the glucometer. During the survey the facility obtained the correct manual for the glucometer used by the facility. On 10/14/19 at 2:35 PM, RN #1 was observed to run controls on the glucometer. While performing the procedure it was noted the RN failed to cycle the glucometer to the "Control" mode as instructed by the manual. The RN stated she was not aware this had to be done when

	running quality controls on the glucometer. Interview with the Clinic Manger on 10/14 /19 at 1:20 PM revealed the facility had previously used a different glucometer and had not obtained the manual for the current glucometer due to an oversight.