

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RECEIVED

PRINTED: 05/10/2010
FORM APPROVED
OMB NO. 0938-0391

MAY 20 2010

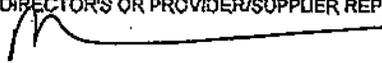
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/28/2010
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NAME OF PROVIDER OR SUPPLIER BELCOURT TERRACE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 BELCOURT AVENUE NASHVILLE, TN 37212
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(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
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F 164 SS=E	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law, third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain residents' personal privacy and/or failed to maintain the confidentiality of residents' medical/medication information on 2 of 2 (Hall 1 and Hall 2) halls.</p>	F 164	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the facts alleged, or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. The plan of correction constitutes our credible allegation of compliance.</p> <p>F-164 Privacy s/s= E</p> <ol style="list-style-type: none"> I. Resident medical/medication information is being kept confidential. Resident #5 and Resident #6 are being provided cares in privacy. II. Resident medical information is being kept confidential and/or closed or covered when on the medication cart on the units. Residents are receiving cares in a manner to maintain their privacy. III. Nursing staff has been re-educated on keeping medical information confidential. Nursing staff has been re-educated on providing privacy during cares, knocking on the residents' doors and/or receiving permission from the resident. 	5/28/10
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accountable POC 5/20/10 LP PIVUL

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X8) DATE 5/19/2010
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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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F 164	<p>Continued From page 1</p> <p>The findings included:</p> <p>1. Observations on Hall 1 on 4/26/10 at 7:20 PM, revealed the Medication Administration Record was left open and unattended on top of the medication cart with resident information visible to anyone who passed by.</p> <p>Observations on Hall 1 on 4/26/10 at 9:55 PM, revealed a Neurological Assessment flowsheet was laying on top of the medication cart unattended with resident information visible to anyone who passed by.</p> <p>Observations in Resident #5's room (17B) on Hall 1 on 4/27/10 at 9:35 AM, revealed Nurse #3 entered the adjoining bathroom to wash her hands while a resident was sitting on the commode in the bathroom.</p> <p>2. Observations on Hall 2 on 4/27/10 at 4:00 PM, revealed Nurse #5 entered Room 27 without knocking or receiving permission from the resident to enter the room.</p> <p>Observations on Hall 2 on 4/27/10 at 4:35 PM, revealed Nurse #5 entered Room 28 without knocking or receiving permission from the resident to enter the room.</p> <p>Observations on Hall 2 on 4/27/10 at 5:13 PM, revealed Nurse #5 entered Room 31 without knocking or receiving permission from the resident to enter the room.</p> <p>Observations in Resident #6's room (31A) on Hall 2 on 4/27/10 at 5:13 PM, revealed Nurse #5 administered an insulin injection into Resident #5's abdomen. The door to Resident #5's room</p>	F 164	<p>IV. The Administrator, Director of Nursing and/or Designee will complete random audits of medication carts for confidentiality and for cares being provided in privacy, including knocking on doors, 2 times a week for 4 weeks, weekly for 4 weeks, then monthly for 2 months. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.</p> <p>V. Completion Date:</p>	5/28/10	

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F 164	Continued From page 2 was left open and Resident #5's abdomen was visible to anyone who passed by. Observations during a dressing change in Random Resident (RR) #4's room (30A) on Hall 2 on 4/28/10 at 11:40 AM, revealed the Assistant Director of Nursing (ADON) and Nurse #1 left the bathroom door open to the adjoining room exposing RR #4 to anyone that entered the bathroom. During an interview on Hall 2 on 4/28/10 at 3:55 PM, the ADON stated, "Left the door open to save time. I know I should have closed it [the door]."	F 164			
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations and an interview, it was determined the facility failed to provide a fine dining experience by not serving the breakfast trays timely for 2 of 12 (Residents #1 and 8) sampled residents and Random Resident (RR #2) during 1 of 2 (breakfast) dining observations. The findings included: Observations of the breakfast meal on Hall 1 on 4/27/10 revealed the following: a. The breakfast meal cart for Hall 1 was delivered at 8:15 AM.	F 252	F-252 Environment s/s=D I. Resident #1, #2 and #8 are receiving their breakfast meals in a timely manner. II. Resident meals are being audited and are receiving meals in a timely manner. III. Nursing and Dietary staff have been re-educated on serving times for meals. IV. The Director of Nursing, Dietary Service Manager and/or Designee will complete random audits of meal service times 3 times a week for 4 weeks, weekly for 4 weeks, then monthly for 2 months. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed. V. Completion Date:	5/28/10	

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F 252	Continued From page 3 b. RR #2's breakfast tray was not delivered until 8:50 AM, 35 minutes past the time the cart arrived on Hall 1. c. Resident #8's breakfast tray was not delivered until 8:52 AM, 37 minutes past the time the cart arrived on Hall 1. d. Resident #1's breakfast tray was not delivered until 9:13 AM, 58 minutes past the time the cart arrived on Hall 1. During an interview on Hall 1 on 4/27/10 at 9:13 AM, Certified Nursing Technician (CNT #1) stated, "Yes, this is the last one [last breakfast tray to be served from the cart]."	F 252			
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit;	F 272			

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F 272	Continued From page 4 Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and an interview, it was determined the facility failed to complete an initial Minimum Data Set (MDS) assessment for 1 of 13 (Resident #6) sampled residents. The findings included: Medical record review for Resident #6 documented and admission date of 4/6/10 with diagnoses that included Anxiety, Depression Disorder, Cushing syndrome, Fibromyalgia, Rheumatoid Arthritis, Diabetes Mellitus and Vasculitis. The facility staff had not completed an initial MDS assessment for Resident #6 since the admission date of 4/6/10. During an interview in the Assistant Director of Nurse's (ADON) office on 4/27/10 at 3:18 PM, the MDS Coordinator stated, "There is nothing on her [Resident #6]. I had to be out [away from the facility from 4/5/10 to 4/26/10] after I started to work here. This is my first day back; I guess she [Resident #6] just didn't get done."	F 272	F-272 Assessments s/s= D I. Resident #6's MDS (Minimum Data Set) assessment has been completed. II. Resident charts have been audited and MDS (Minimum Data Set) assessments have been completed per the RAI (Resident Assessment Instrument) guidelines. III. The MDS/Care Plan team has been re-educated on time frames for completion of MDS (Minimum Data Set) assessments. IV. The Director of Nursing, MDS Coordinator and/or Designee will complete random audits of MDS (Minimum Data Set) assessments weekly for 4 weeks, then monthly for 3 months. Results of the audits will be reviewed at the Quality Assurance meeting for revisions as needed. V. Completion Date:		
F 280 SS=D	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	F 280		5/28/10	

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F 280	<p>Continued From page 5</p> <p>Incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and an interview, it was determined the facility failed to revise the comprehensive plan of care to reflect interventions for pain or falls for 2 of 13 (Residents #9 and 10) sampled residents.</p> <p>The findings included:</p> <p>1. Medical record review for Resident #9 documented an admission date of 6/19/08 with diagnoses of Paraplegia, Spina Bifida with Hydrocephalus, Neurogenic Bladder and Chronic Pain. Review of the Minimum Data Set (MDS) dated 3/15/10 documented, "...Section J2 Pain Symptoms a. Frequency 1. Pain less than daily and b. Intensity of pain 1. Mild pain." Review of the as needed (PRN) medication</p>	F 280	<p>F-280 Care Plan Revisions s/s= D</p> <p>I. Resident #9 has a care plan to address pain related to headaches. Resident #10 has a care plan to address current fall interventions.</p> <p>II. Resident care plans have been reviewed and reflect current interventions for pain management and fall prevention measures.</p> <p>III. The care plan team and licensed nurses have been re-educated on revising care plans as needed to reflect current care needs and interventions.</p> <p>IV. The Director of Nursing, MDS Coordinator and/or Designee will complete random audits of the care plans weekly for 4 weeks, then monthly for 3 months. Results of the audits will be reviewed at the Quality Assurance meeting for revisions as needed.</p> <p>V. Completion Date:</p>	5/28/10	

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F 280	Continued From page 6 flowsheet for Resident #9 dated March 2010 documented Buffered Aspirin 325 milligrams (mg) 2 tablets administered for complaints of headache on 3/1/10, 3/2/10, 3/3/10, 3/9/10, 3/15/10, 3/19/10, 3/20/10, 3/22/10, 3/23/10, 3/24/10, 3/26/10, 3/29/10, 3/30/10 and 3/31/10. The care plan was not updated to include interventions for pain. During an interview in the MDS office on 4/28/10 at 10:30 AM, the MDS Coordinator stated, "I can't find it [care plan for pain]..." 2. Medical record review for Resident #10 documented an admission date of 2/4/10 with diagnoses of Advanced Lung Cancer, Esophageal Reflux, Anxiety, Pain, and Significant Weight Loss. Review of the physician's orders dated 4/1/10 documented, "...Bed alarm while in bed to alert staff of unassisted transfers..." The care plan dated 2/23/10 was not updated to include the bed alarm intervention for falls.	F 280			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and an interview, it was determined the facility failed to follow the comprehensive care plan for quarterly abnormal involuntary movement scale (AIMS) testing for 1 of 13 (Resident #3) sampled residents.	F 282	F-282 Provide Care as per Plan of Care s/s=D I. AIMS testing has been completed for Resident #3 as per plan of care. II. Resident audits have been completed and Residents requiring an AIMS has been completed as per plans of care. III. The care plan team and licensed nurses have been re-educated on completion of AIMS testing and following the plan of care.	5/28/10	

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F 282	<p>Continued From page 7</p> <p>The findings included:</p> <p>Medical record review for Resident #3 documented an admission date of 10/15/08 with a readmission date of 2/26/10 with diagnoses of Dementia Without Behavior Disturbances, Hypothyroidism and Nonorganic Psychosis. Review of the comprehensive care plan dated 3/30/10 documented, "...Problem: Risk for medication side effects related to anti-psychotic drug use. Approach: ...AIMS testing quarterly for anti-psychotics..." Review of the AIMS tests revealed testing was done on 4/15/09, 9/25/09 and 2/28/10. The facility was unable to provide documentation of the AIMS testing being done quarterly as care planned.</p> <p>During an interview on Hall 2 on 4/28/10 at 10:40 AM, the Assistant Director of Nursing verified that the AIMS testing had not been done quarterly as care planned.</p>	F 282	<p>IV. The Director of Nursing, MDS Coordinator and/or Designee will complete random audits for AIMS testing and following the plans of care weekly for 4 weeks, then monthly for 3months. Results of the audits will be reviewed at the Quality Assurance meeting for revisions as needed.</p> <p>V. Completion Date:</p>	5/28/10
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and interviews, it was determined the facility failed to provide necessary care and services according to physician's orders for chair alarm for 1 of 13</p>	F 309		

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F 309	Continued From page 8 (Resident #3) sampled residents. The findings included: Medical record review for Resident #3 documented an admission date of 10/15/08 with a readmission date of 2/26/10 with diagnoses of Dementia without behavior disturbances, Hypothyroidism and Nonorganic Psychosis. Review of a physician's order dated 4/1/10 documented, "...Chair alarm to alert staff of attempts to rise unassisted and check placement and function q [every] shift..." Observations in Resident #3's room on 4/27/10 at 7:30 AM, and on 4/28/10 at 10:55 AM, revealed Resident #3 seated in a wheelchair with no chair alarm in place. Observations in the dining room on 4/27/10 at 8:20 AM, and on 4/28/10 at 4:30 PM, revealed Resident #3 seated in a wheelchair with no chair alarm in place. Observations in the hallway across from the nurse's station on 4/27/10 at 11:45 AM, 3:00 PM, and 3:45 PM, revealed Resident #3 seated in a wheelchair with no chair alarm in place. During an interview in the dining room on 4/27/10 at 8:20 AM, when asked if Resident #3 had a chair alarm on the Certified Nursing Technician #7 stated, "No she [Resident #3] doesn't." During an interview in the dining room on 4/28/10 at 4:30 PM, the Assistant Director of Nursing verified that Resident #3 did not have a chair alarm in place.	F 309	F-309 Care and Services s/s=D I. Resident #3 is using the chair alarm as ordered by the physician. II. An audit of physician orders and devices has been completed. Residents are receiving devices as ordered by the physician. III. Nursing staff has been re-educated on reviewing physician orders and monitoring that physician ordered devices are in place. IV. The Director of Nursing, Assistant Director of Nursing and /or Designee will complete random audits of physician ordered devices 3 times a week for 4 weeks, weekly for 4 weeks, then monthly for 2 months. Results of the audits will be reviewed at the Quality Assurance meeting for revisions as needed. V. Completion Date: 5/28/10	
F 315	483.25(d) NO CATHETER, PREVENT UTI,	F 315		

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F 315 SS=E	<p>Continued From page 9</p> <p>RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the "CNA [Certified Nursing Assistant] Candidate Handbook", policy review, observations, and interviews, it was determined the facility failed to ensure that pericare was performed according to facility policy for 1 of 1 (Resident #2) sampled resident observed receiving pericare and correct catheter care for 2 of 2 (Residents #1 and 9) sampled residents observed receiving catheter care.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's Perineal Care policy documented, "...(1) Separate labia... (2) Continue to wash the perineum moving outward to and including thighs..." 2. Review of "CNA Candidate Handbook" Version 4.5 October 2009, Skill #7 - Catheter Care" documented, "...9. Uses soap and water to carefully wash around the drainage tube where it exits the urethra. 10. ...clean 3- [to] 4 inches from the urethra down the drainage tube. 11. Cleans 	F 315	<p>F-315 Urinary/Prevent UTI s/s=E</p> <ol style="list-style-type: none"> I. Resident #2 is receiving pericare as per recommended guidelines. Resident #1 and #9 are receiving catheter care as per recommended guidelines. II. Residents have been assessed and are receiving pericare and/or catheter cares as per recommended guidelines. III. Nursing assistants have been re-educated on guidelines for providing pericare and catheter care. Nursing assistants have completed return demonstrations. IV. The Director of Nursing, Assistant Director of Nursing and/or Designee will complete random audits of staff providing pericare and/or catheter cares weekly for 4 weeks, then monthly for 3 months. Results of the audits will be reviewed at the Quality Assurance meeting for revisions as needed. V. Completion Date: 	5/28/10

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(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	
F 315	<p>Continued From page 10</p> <p>with strokes only away from the urethra, uses a clean portion of the wash cloth with each stroke."</p> <p>3. Observations in Resident #2's room on 4/28/10 at 11:15 AM, revealed Certified Nursing Technician (CNT) #2 performed pericare on Resident #2. Resident #2 was positioned on her back. CNT #2 lowered the diaper in the front and performed pericare by cleaning the right groin in a downward motion front to back, changed the cloth and then repeated same technique on the left groin. CNT #2 then cleaned the middle of Resident #2's vaginal area without separating the labia. CNT #2 then rinsed the areas and dried. CNT #2 then removed the gloves, then donned gloves (without washing hands) and repositioned the resident to her right side and removed the diaper. CNT #2 then removed gloves and discarded in trash. CNT #2 did not wash her hands. CNT #2 then donned gloves and washed the rectal area front to back, rinsed, and dried. CNT #2 then removed gloves, did not wash her hands and went to the resident's closet and got a clean diaper. CNT #2 donned gloves and placed a diaper Resident #2. CNT #2 proceeded to dress the resident. Nurse #1 observed the pericare procedure performed by CNT #2.</p> <p>During an interview in room #5 on 4/28/10 at 2:10 PM, Nurse #1 was asked what procedure is expected when CNTs perform pericare. Nurse #1 stated, "She [CNT #2] didn't separate the labia like she should have to clean really good."</p> <p>4. Observations in Resident #1's room on 4/27/10 at 3:42 PM, revealed CNT #4 performed catheter care. CNT #4 washed her hands and put on non-sterile gloves. Resident #1 was lying on her back. CNT #4 folded a washcloth, and</p>	F 315			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/28/2010
NAME OF PROVIDER OR SUPPLIER BELCOURT TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1710 BELCOURT AVENUE NASHVILLE, TN 37212	
(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
F 315	Continued From page 11 washed from top to bottom on the right side of labia, then up and down with the soiled washcloth. Using a second washcloth CNT #4 washed from the top to the bottom on left side of labia then up and down using the soiled area of the washcloth. 5. Observations in Resident #9's room on 4/28/10 at 9:08 AM, revealed CNT #6 performed supra-pubic catheter care on Resident #9. CNT #6 unfastened the disposable adult diaper on Resident #9, but did not remove the diaper from under Resident #9. CNT #6 left on the dirty gloves and washed the supra-pubic catheter from skin toward leg drainage bag and then washed up the tube toward the catheter site. CNT #6 then used a dry washcloth to dry the catheter site, then used the same area of the washcloth to dry the catheter tubing.	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by:	F 322		

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F 322	<p>Continued From page 12</p> <p>Based on policy review, medical record review, observations and interviews, it was determined the facility failed to ensure staff checked the placement of a Percutaneous Endoscopic Gastrostomy (PEG) tube prior to administering medications for 1 of 2 (Resident #1) and failed to ensure a PEG tube feeding was administered continuously as ordered by the physician for 1 of 2 (Resident 5) sampled residents with PEG tubes.</p> <p>The findings included:</p> <p>1. Review of the facility's "Medication Administration via Feeding Tubes" policy documented, "...Verify tube placement by forcefully injecting air into tube while listening to the abdomen with stethoscope for a bubbling sound..."</p> <p>2. Medical record review for Resident #1 documented an admission date of 7/22/09 with diagnoses of Renal Disease, Adult Failure To Thrive and Dysphagia. Review of a physician's order dated 4/10 documented, "...Lasix (furosemide) liquid; 10 mg/ml [milligrams per milliliter]; give 2ml; gastric tube Daily...Lortab 5/500 (acetaminophen-hydrocodone) - Schedule III tablet; 500 mg-5 mg; gastric tube BID-Twice a Day..."</p> <p>Observations in Resident #1's room on 4/27/10 at 8:35 AM, revealed Nurse #3 administered Lasix 20mg and Lortab 5/500 via PEG tube to Resident #1. Nurse #3 did not check the PEG tube placement prior to administering the medications.</p> <p>3. Medical record review for Resident #5 documented an admission date of 1/8/07 with</p>	F 322	<p>F-322 Feed Tubes s/s=D</p> <p>I. Resident #1 is having PEG tube placement checked as per recommended guidelines. Resident #5 is receiving their PEG tube feeding as ordered by the physician.</p> <p>II. Residents with PEG tubes are having placement checked as per recommended guidelines. Residents with PEG tube feedings are receiving the feeding as ordered by the physician.</p> <p>III. Licensed nurses have been re-educated on checking placement of PEG tubes as per recommended guidelines and on tube feeding administration.</p> <p>IV. The Director of Nursing, Assistant Director of Nursing and/or Designee will complete random audits of PEG tubes during medication passes and feedings, weekly for 4 weeks, then monthly for 2 months. Results of the audits will be reviewed at the Quality Assurance meeting for revisions as needed.</p> <p>V. Completion Date:</p>	5/28/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/28/2010
NAME OF PROVIDER OR SUPPLIER BELCOURT TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1710 BELCOURT AVENUE NASHVILLE, TN 37212		
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F 322	<p>Continued From page 13</p> <p>diagnoses of Dementia, Convulsions, Diabetes Mellitis and Gastrostomy. Review of a physician's order dated 4/1/10 documented "MVI [multivitamin] liquid 10 cc [cubic centimeter]; gastric tube Daily... Dilantin-125 (phenytoin) suspension; 125 mg/5 ml; amt [amount]: 9cc; gastric tube...BID- Twice a Day..."</p> <p>Observations in Resident #5's room on 4/27/10 at 9:35 AM, revealed Nurse #3 flushed Resident #5's PEG tube with 30cc's of water prior to checking PEG tube placement.</p> <p>During an interview at the nurse's station on 4/28/10 at 2:25 PM, Nurse #3 stated, "Need to always check placement before giving meds [medications]."</p> <p>During an interview in the Director of Nursing's (DON) office on 4/28/10 at 11:15 AM, the DON stated, "They [nurses] are to check tube placement before giving meds."</p> <p>4. Medical record review for Resident #5 documented an admission date of 1/8/07 with diagnoses of Dementia, Convulsions, Diabetes Mellitis and Gastrostomy. Review of the physician's orders dated 4/1/10 documented, "...GLUCERNA TUBE FEEDING TO RUN @ [at]100CC/HR [cubic centimeters per hour] X [times] 20 HRS... tube feeding off from 8 am to 10 am and from 8 pm to 10 pm for dilantin BID - Twice a Day..."</p> <p>Observations in Resident #5's room on 4/27/10 at 4:30 PM, revealed the enteral pump with the Glucerna feeding was turned off with the tubing hanging on the pump pole.</p>	F 322			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER BELCOURT TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1710 BELCOURT AVENUE NASHVILLE, TN 37212	
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F 322	Continued From page 14 During an interview in Resident #5's room on 4/27/10 at 4:50 PM, the DON was asked why the feeding was turned off. The DON stated, "He [Resident #5] has been to activities twice today. They unhooked him to go. It [the tube feeding] shouldn't be off." During an interview at the nurse's station on 4/27/10 at 5:00 PM, Nurse #2 was asked about Resident #5's enteral feeding being turned off. Nurse #2 stated, "I connected the tube. It blowed out. I left it out. I turned it off when I came in at 3:00."	F 322		
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. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and an interview, it was determined the facility failed to implement interventions to prevent accidents such as falls for 1 of 2 (Resident #10) sampled residents with a history of falls. The findings included: Medical record review for Resident #10 documented an admission date of 2/4/10 with diagnoses of Advanced Lung Cancer, Esophageal Reflux, Anxiety, Pain, and Significant	F 323	F-323 Accident/Injury s/s=D I. Resident #10 is using the bed alarm as ordered by the physician. II. Residents with physician ordered alarms have been assessed and are using alarms as ordered by the physician. III. Nursing staff has been re-educated on providing alarms and monitoring for placement as ordered by the physician. IV. The Director of Nursing, Assistant Director of Nursing and/or Designee will complete random audits of bed alarms weekly for 4 weeks, then monthly for 3 months. Results of the audits will be reviewed at the Quality Assurance meeting for revisions as needed. V. Completion Date:	5/28/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 323	Continued From page 15 Weight Loss. The physician's orders dated 4/1/10 documented, "...Bed alarm while in bed to alert staff of unassisted transfers..." Review of the observation note dated 4/14/10 documented, "resident slid off bed, sitting on floor." Observations in Resident #10's room on 4/27/10 at 10:05 AM, revealed Resident #10 sitting on the side of the bed with no bed alarm attached. During an interview in Resident #10's room on 4/27/10 at 10:10 AM, Nurse #6 was asked to show the surveyor the bed alarm that was used for Resident #10. Nurse #6 removed the unattached bed alarm string from under the bottom sheet and stated, "It's supposed to be clipped to his shirt... they [certified nursing technicians] put the sheet over the string. It [bed alarm] doesn't do any good that way."	F 323			
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on review of the Mosby's 2009 Nursing Drug Reference book, policy review, medical record review, observations and interviews, it was determined the facility failed to ensure 3 of 4 (Nurses #2, 4 and 5) nurses administered medications without a medication error rate of less than 5 percent (%) for sampled Residents #6 and #8. A total of 5 errors were observed out of 42 opportunities for error, resulting in a medication error rate of 11.90%.	F 332			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

HEALTH CARE FACILITY Fax: 731-512-0063

May 10 2010 05:16pm P020/053
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/28/2010
NAME OF PROVIDER OR SUPPLIER BELCOURT TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1710 BELCOURT AVENUE NASHVILLE, TN 37212	
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F 332	<p>Continued From page 16</p> <p>The findings included:</p> <p>1. Review of the facility's insulin injection policy documented, "... policy-Insulin is administered per physician's orders... Procedure-Rotate vial of insulin between hands and invert several times to mix..."</p> <p>Medical record review for Resident #6 documented an admission date of 4/6/10 with diagnoses of Cushing Syndrome, Chronic Renal Disease, Failure To Thrive and Fibromyalgia. Review of a physician's order dated 4/14/10 documented, "...NovoLin (insulin aspart) 121- [to] 150= [amount of insulin to be administered] 2u [units], 151-200=3u, 201-250=6u, 251-300=9u, 301-360=12u, 361-400=15u and re-check in 2 hrs [hours] if remains over 400 notify MD [Medical Doctor] solutions: 100 units/ [per] ml [milliliter]; amt [amount]: see above; subcutaneous AC [before meals] & [and] HS [at bedtime]..."</p> <p>Observations in Resident #6's room on 4/26/10 at 8:30 PM, revealed Nurse #2 administered 2 units of Novolin R insulin to Resident #6. The administration of the Novolin R without a physician's order resulted in medication error #1.</p> <p>Observations in Resident #6's room on 4/27/10 at 11:45 AM, revealed Nurse #4 administered 2 units of Novolin N insulin to Resident #6. Nurse #2 did not rotate or roll the vial of insulin prior to drawing up the insulin. The administration of the Novolin N without a physician's order resulted in medication error #2.</p> <p>Observations in Resident #6's room on 4/27/10 at 5:13 PM, revealed Nurse #5 administered 15</p>	F 332	<p>F-332 Medication Error s/s=E</p> <p>I. Resident #6 is receiving the correct insulin as ordered by the physician. The insulin is being administered as per recommended guidelines. Resident #8 is receiving eye drops and oral medications as per recommended guidelines.</p> <p>II. Physician orders have been reviewed. Residents are receiving insulin, eye drops and oral medications as ordered by the physician and per recommended guidelines for administration.</p> <p>III. Licensed nurses have been re-educated on administration of insulin, eye drops and oral medications as per physician orders and recommended guidelines.</p> <p>IV. The Director of Nursing, Assistant Director of Nursing and/or Designee will complete random medication pass audits 2 times a week for 4 weeks, weekly for 4 weeks, then monthly for 2 months. Results of the audits will be reviewed at the Quality Assurance meeting for revisions as needed.</p> <p>V. Completion Date:</p>	5/28/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESFORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/28/2010
NAME OF PROVIDER OR SUPPLIER BELCOURT TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1710 BELCOURT AVENUE NASHVILLE, TN 37212	
(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
F 332	<p>Continued From page 17</p> <p>units of Novolin R insulin to Resident #6. The administration of the Novolin R without an order resulted in medication error #3.</p> <p>During a telephone interview in the Social Service's Director's office on 4/28/10 at 10:20 AM, the Pharmacist stated, "Have an order for the Novolog to be dc'd [discontinued] on 4/14/10. Should have clarified the order as to the type of Novolin as Novolin has R, N and 70/30, although it's usually Novolin R. I would have clarified the order if I had taken it, there is no Novolin insulin aspart. The only insulin aspart is Novolog. I will check with the doctor to see what he actually wants."</p> <p>During an interview in the Director of Nursing's (DON) office on 4/28/10 at 11:15 AM, the DON stated, "When an order is unclear the nurses should notify me and call the doctor for clarification. If still unclear they should notify me again. Don't expect them to follow an order they are uncertain about. We'll get that order [referring to the insulin order] clarified immediately."</p> <p>During an interview at the nurse's station on 4/28/10 at 2:25 PM, Nurse #4 stated, "Made a medication error, gave the wrong insulin."</p> <p>3. Review of the facility's medication administration policy documented, "...Proper Administration of Ophthalmic Solutions /Suspensions... If administering more than one drop of medication at the same time, wait at least 3 to 5 minutes in between drops..."</p> <p>Review of the 2009 Mosby's Nursing Drug Reference, 22nd edition page 952 documented, "Uses: End-stage renal disease (ESRD)... Adult:</p>	F 332		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

HEALTH CARE FACILITY Fax: 731-512-0063

May 10 2010 05:17pm P022/053
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/28/2010
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NAME OF PROVIDER OR SUPPLIER BELCOURT TERRACE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 BELCOURT AVENUE NASHVILLE, TN 37212
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(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
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F 332	<p>Continued From page 18</p> <p>PO [by mouth] Initially 800 - 1600 mg tid [three times daily] with meals..."</p> <p>Medical record review for Resident #8 documented an admission date of 11/23/09 with diagnoses of ESRD and Hypertension. Review of a physician's order dated 4/10 documented, "...Pred Forte (prednisolone ophthalmic) suspension: acetate 1%; ...Special Instructions; RT [right] EYE QID- Four Times A Day... Timoptic Ocumeter (timolol ophthalmic) solution; 0.5%... BIL [bilateral] EYES BID-Twice a Day...Renvela tablet 800mg [milligrams] 3 tabs [tablets]; oral TID- Three Times A Day..."</p> <p>Observations in Resident #8's room on 4/25/10 at 8:45 PM, revealed Nurse #2 administered Timolol eye drops (gts) to Resident #8 one gtt to each eye. Nurse #2 waited 90 seconds and then administered Prednisolone one gtt to Resident #8's right eye. Failure to wait at least 5 minutes between administration of the eye gtt's resulted in medication error #4.</p> <p>During an interview in the DON's office on 4/26/10 at 11:15 AM, the DON stated, "They [Nurses] are to wait at least five minutes between eye drops."</p> <p>During an interview in Room 15 on 4/28/10 at 5:15 PM, Nurse #2 stated, "I'm sorry I thought I waited long enough."</p> <p>Observations in Resident #8's room on 4/27/10 at 4:35 PM, revealed Nurse #5 administered three 800 mg tablets of Renvela to Resident #8. Failure to administer the Renvela with a meal resulted in medication error #5.</p>	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333		

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F 333	Continued From page 19 The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on review of the 2009 Mosby's Nursing Drug Reference book, policy review, medical record review, observations and interviews, it was determined the facility failed to ensure that residents were free of significant medication errors when 3 of 4 nurses (Nurses #2, 4 and 5) observed during medication administration pass failed to ensure there was an order for the type of insulin to be administered and failed to administer a phosphorus binding medication with meals. The findings included: 1. Review of the facility's insulin injection policy documented, "...Policy-Insulin is administered per physician's orders... Procedure-Rotate vial of insulin between hands and invert several times to mix..." Medical record review for Resident #6 documented an admission date of 4/6/10 with diagnoses of Cushing Syndrome, Chronic Renal Disease, Failure To Thrive and Fibromyalgia. Review of a physician's order dated 4/14/10 documented, "...NovoLin (Insulin aspart) 121- [to] 150= [amount of insulin to be administered] 2u [units], 151-200=3u, 201-250=6u, 251-300=9u, 301-360=12u, 351-400=15u and re-check in 2 hrs [hours] if remains over 400 notify MD [Medical Doctor] solutions: 100 units/ [per] ml [milliliter]; amt [amount]: see above: subcutaneous AC [before meals & [and] HS- [at bedtime]..."	F 333	F-333 Significant Medication Errors s/s=D I. Resident #6 is receiving the correct insulin as ordered by the physician. The insulin is being administered as per recommended guidelines. Resident #8 is receiving oral medications as per recommended guidelines. II. Physician orders have been reviewed. Residents are receiving insulin and oral medications as ordered by the physician and per recommended guidelines for administration. III. Licensed nurses have been re-educated on administration of insulin and oral medications as per physician orders and recommended guidelines. IV. The Director of Nursing, Assistant Director of Nursing and/or Designee will complete random medication pass audits 2 times a week for 4 weeks, weekly for 4 weeks, then monthly for 2 months. Results of the audits will be reviewed at the Quality Assurance meeting for revisions as needed. V. Completion Date:	5/28/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

HEALTH CARE FACILITY Fax: 731-512-0063

May 10 2010 05:17pm P024/053
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NAME OF PROVIDER OR SUPPLIER BELCOURT TERRACE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1716 BELCOURT AVENUE NASHVILLE, TN 37212
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(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
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F 333	<p>Continued From page 20</p> <p>Observations in Resident #6's room on 4/26/10 at 8:30 PM, revealed Nurse #2 administered 2 units of Novolin R insulin to Resident #6.</p> <p>Observations in Resident #6's room on 4/27/10 at 11:45 AM, revealed Nurse #4 administered 2 units of Novolin N insulin to Resident #6.</p> <p>Observations in Resident #6's room on 4/27/10 at 5:13 PM, revealed Nurse #5 administered 15 units of Novolin R Insulin to Resident #6.</p> <p>The administration of the wrong insulin resulted in significant medication errors.</p> <p>During a telephone interview in the Social Service's Director's office on 4/28/10 at 10:20 AM, the Pharmacist stated, "Have an order for the Novolog to be dc'd [discontinued] on 4/14/10. Should have clarified the order as to the type of Novolin as Novolin has R, N and 70/30, although it's usually Novolin R. I would have clarified the order if I had taken it. There is no Novolin insulin aspart. The only insulin aspart is Novolog. I will check with the doctor to see what he actually wants."</p> <p>During an interview in the Director of Nursing's (DON) office on 4/28/10 at 11:15 AM, the DON stated, "When an order is unclear the nurses should notify me and call the doctor for clarification. If still unclear they should notify me again. Don't expect them to follow an order they are uncertain about. We'll get that order [referring to the insulin order] clarified immediately."</p> <p>During an interview at the nurse's station on 4/28/10 at 2:25 PM, Nurse #4 stated, "Made a</p>	F 333		
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NAME OF PROVIDER OR SUPPLIER BELCOURT TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1710 BELCOURT AVENUE NASHVILLE, TN 37212		
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F 333	Continued From page 21 medication error, gave the wrong insulin." 2. Review of the 2009 Mosby's Nursing Drug Reference 22nd edition, page 952 documented, "Uses: End-stage renal disease (ESRD)... Adult PO [by mouth] Initially 800 - 1600 mg tid [three times daily] with meals..." Medical record review for Resident #8 documented an admission date of 11/23/09 with diagnoses of ESRD and Hypertension. Review of a physician's order dated 4/10 documented, "...Renvela tablet 800mg [milligrams] 3 tabs [tablets]; oral TID- Three Times A Day..." Observations in Resident #8's room on 4/27/10 at 4:35 PM, revealed Nurse #5 administered three 800 mg tablets of Renvela to Resident #8. Failure to administer the medication with a meal resulted in a significant medication error.	F 333			
F 368 SS-E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.	F 368			

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F 368	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to offer bedtime snacks to 4 of 6 Random Residents (RR) #6, 7, 8, 9 and sampled Resident #7) residents who attended the resident group interview and RR #5, who was interviewed during the initial tour. The findings included: Observations during the initial tour on 4/26/10 beginning at 7:15 PM, revealed no bedtime snacks were offered. During an interview in RR #5's room on 4/26/10 at 7:16 PM, RR #5 stated she did not receive a bedtime snack. During the group interview held in the dining room on 4/27/10 at 11:15 AM, 4 of the 6 alert and oriented residents (Random Residents #6, 7, 8, and 9 and sampled Resident #7) stated that they did not receive a bedtime snack.	F 368	F-368 HS Snacks s/s=E I. Resident #7 is being offered bedtimes snacks. II. Residents are being offered bedtime snacks. III. Dietary and Nursing staff have been re-educated on passing bedtime snacks to residents. IV. The Director of Nursing, Dietary Manager, and/or Designee will complete random audits of bedtime snack pass weekly for 4 weeks, then monthly for 3 months. Results of the audits will be reviewed at the Quality Assurance meeting for revisions as needed. V. Completion Date:	5/28/10
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on menu review, observations and interviews, it was determined the facility failed to maintain sanitary conditions, properly cover and/or date open foods, thaw meats to prevent cross contamination, serve milk at 41 degrees Fahrenheit (F) or less, properly clean surfaces and equipment and educate staff on dishwashing machine sanitation which could affect 37 of 39 residents residing in the facility. The findings included: 1. Observations in the kitchen during the initial tour on 4/26/10 beginning at 7:20 PM revealed two dietary staff (one cook and one dietary assistant) members present performing various cleaning tasks. The dietary assistant stated, "We usually leave at 7:00 to 7:15 PM." One or both staff members were present during the tour of the kitchen. Observations during the initial tour of the kitchen on 4/26/10 beginning at 7:20 PM revealed the following: a. A mop in a bucket of dirty water in front of the Reach-In Freezer. b. The top shelf of the food preparation table was dusty with a greasy film. The shelf also had 2 bananas in different places along with various haphazardly placed items including kitchen and non kitchen items. c. The lid to the corn meal storage container was partially covering the container. d. Three of four steam table pans had debris on them.	F 371	F-371 Dietary Sanitation s/s=F I. The mop bucket is being stored when mopping is complete. The top shelf of food preparation table has been cleaned and bananas are stored with food items. The lid is secure on the corn meal storage container. The steam table pans have been cleaned. The coffee pot lid has been cleaned/dried. The slice of chocolate pie was discarded. The plastic around the pulled turkey and biscuits were secured. Meat and liquid eggs are stored separately. The covering on the chicken was secured. Food items without dates are discarded. The meat slicer has been cleaned. The salt is stored in a closed container. Foods are being thawed on the bottom shelf in the refrigerator. Milk is being served at appropriate temperatures. The dish machine is meeting appropriate wash/rinse temperatures and being checked with sanitation strips.		

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F 371	<p>Continued From page 24</p> <p>e. A coffee pot lid was left to dry in a puddle of water on the counter.</p> <p>During an interview in the kitchen on 4/26/10 at 7:20 PM, the Cook stated, "We just washed it [coffee pot lid]."</p> <p>Observations of the reach-in-freezer on 4/26/10 beginning at 7:20 PM revealed the following:</p> <p>a. A slice of chocolate pie in a disposable aluminum pan inside an open plastic storage bag. The bag was not dated.</p> <p>b. Pulled turkey in an open plastic bag inside an unsealed cardboard box.</p> <p>c. An open plastic bag of 30.25 pounds of frozen biscuits.</p> <p>Observations of the reach-in-refrigerator on 4/26/10 beginning at 7:20 PM revealed the following:</p> <p>a. Ground beef in a plastic bag sealed with a twist tie, chicken pieces in a plastic bag sealed with a twist tie and a precooked factory shrink wrapped 5 lb. deli styled turkey roll, were crowded close together in one oblong baking pan. The pan was sitting on top of an open cardboard box that contained unopened packages of factory sealed bags of liquid eggs.</p> <p>b. A large tall pan of chicken pieces, very loosely covered with aluminum foil. The foil did not form a seal and left openings where it did not connect with the pan.</p> <p>c. Tuna salad was in a small pan covered with plastic wrap and not dated.</p> <p>d. Potato salad was in a small pan covered with plastic wrap and not dated.</p> <p>During an interview in the kitchen on 4/26/10 beginning at 7:20 PM, the Cook stated, "Those</p>	F 371	<p>II. Cleaning supplies have been checked and are being stored. The kitchen has been checked and cleaned. Food items are being stored in secured containers. Food items that are opened in the refrigerator have dates. Food items in the refrigerator and freezer are in secured containers/wrappings. Food items in the refrigerator to be thawed, are separate from the liquid eggs and on the bottom shelf. Milk is being served at appropriate temperatures. The dish machine is meeting required wash/rinse temperatures and is being checked with a sanitations strip.</p> <p>III. The sanitation check lists have been reviewed and revised to meet current needs. The dietary staff has been re-educated on kitchen sanitation procedures.</p> <p>IV. The Administrator, Director of Nursing, Registered Dietitian, Dietary Manager and/or Designee will complete random sanitation audits 3 times a week for 4 weeks, weekly for 4 weeks, then monthly for 2 months. Results of the audits will be reviewed at the Quality Assurance meeting for revisions as needed.</p> <p>V. Completion Date:</p>	5/28/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44527S	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/28/2010
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NAME OF PROVIDER OR SUPPLIER BELCOURT TERRACE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 BELCOURT AVENUE NASHVILLE, TN 37212
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F-371	<p>Continued From page 25</p> <p>are thawing [the meats in the refrigerator]. We are going to have meat loaf and chicken tomorrow. The turkey is for turkey sandwiches."</p> <p>Review of the menu for the next day (4/27/10) documented meat loaf for lunch and ham for dinner. The menu documented chicken had been served for lunch on 4/26/10. It was not documented on the menu that chicken or turkey sandwiches were alternates for any of the 4/27/10 meals.</p> <p>2. Observations of the kitchen with the Dietary manager and the Dietician present on 4/27/10 beginning at 11:55 AM revealed the following:</p> <p>a. A mop in a bucket of dirty water in front of the reach-in freezer.</p> <p>b. A slicer, covered in plastic had a piece of a hard plastic wrap (similar to what factories use to shrink seal meat), a piece of regular plastic wrap on different parts of the machine, loose crumbs and dried debris.</p> <p>c. The dry storage area had salt stored on a shelf in a large unsealed paper bag inside a large unsealed plastic bag.</p> <p>d. The reach-in refrigerator had a plastic bag of chicken pieces sealed with a twist tie and a precooked factory shrink wrapped 5 lb. dell styled turkey roll were in the same oblong pan. The pan had a small amount of thin cloudy liquid on the bottom. The pan was sitting on top of an open cardboard box lined with parchment paper that contained raw bacon. The box of raw bacon was sitting on top of an open cardboard box that contained unopened packages of factory sealed bags of liquid eggs.</p> <p>During an interview in the kitchen on 4/27/10 beginning at 11:55 AM, the Dietary Manager (DM)</p>	F-371		
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F 371	<p>Continued From page 26</p> <p>stated: "If it's [the slicer] covered in plastic, it's suppose to be clean." The DM was asked about the salt. The DM stated, "They [staff] bring down a bowl or cups and scoop it [salt out of the bag]."</p> <p>During an interview in the kitchen on 4/27/10 beginning at 11:55 AM, the Dietician stated that she would expect thawing foods to be in pans on the bottom shelf, and would not expect the pans to be on top of boxes.</p> <p>3. Observations in the kitchen of the tray line on 4/27/10 beginning at 12:10 PM, revealed two trays had been prepared with milk placed on the tray and the trays placed in the meal tray cart. The cook checked the temperature of a carton of milk waiting to be placed on meal trays. The temperature of the milk was 43 degrees F.</p> <p>During an interview in the kitchen, during the trayline on 4/27/10 beginning at 12:10 PM, the cook stated, "It [temperature of the milk] will get better the longer it stays out. The temperature will go up." Dietary Assistant #2 tested another milk carton, waiting to be placed on the food trays. The temperature of the milk was 42 degrees F. Dietary Assistant #2 stated, "That's okay. It [temperature of the milk] will get better by the time it's served." Immediately following the testing of the food and milk temperatures. The Dietician stated,</p> <p>During an interview in the kitchen on 4/27/10 following taking of the food and milk temperatures. The Dietician stated, If the milk is 42 or 43 degrees, she would expect them not to use that milk, and cover the remaining cartons with more ice.</p>	F 371		

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F 371	Continued From page 27 4. Observations and interviews in the dishwashing area with the Dietary Manager and the Cook present on 4/27/10 at 3:25 PM, revealed the dishwashing machine had a clear, well placed label stating the dishwasher had hot water sanitation and the water needed to reach 180 degrees for sanitation. The Dietary Manager was asked what temperature had to be reached for sanitation? The DM stated, "159 degrees." The surveyor rephrased the question to ask what temperature was required for the sanitation of the dishes. The DM stated, "between 120 degrees and 180 degrees. I really should know that." The cook (whose responsibility included dishwashing) was asked how he tested the dishes for sanitation. The Cook stated, "With this strip." The cook showed the surveyor a strip used to test sanitation when using quaternary sanitizing solution. The Cook demonstrated with an unsatisfactory results. Referring to the unsatisfactory results, the Cook stated that was because "the water was dirty and I usually put some bleach in the water." The surveyor then asked the cook at what temperature sanitation occurs. The Cook stated, "159 degrees or so." Then Cook stated, "but the temperature keeps going up to about 179 to 180 degrees."	F 371			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431			

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F 431	<p>Continued From page 28</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observations and an interview, it was determined the facility failed to ensure a medication cart was not left open and medications were not left unattended on top of the medication cart for 1 of 4 (Hall 1 medication cart) medication storage areas.</p> <p>The findings included:</p> <p>1. Review of the facility's medication storage documented, "POLICY: A. Medications are to be stored in a secure manner, under proper</p>	F 431	<p>F-431 Drug Storage s/s=D</p> <p>I. Medications are being secured inside the medication cart. The medication cart is being kept locked when not in contact with the licensed nurse. The medication cart keys are being secured by the licensed nurse.</p> <p>II. Medication carts have been checked, they are being locked and the medication and keys are secured.</p> <p>III. Licensed nurses have been re-educated on securing the medications, medication cart and keys.</p> <p>IV. The Director of Nursing, Assistant Director of Nursing and/or Designee will complete random audits of the medication carts 2 times a week for 4 weeks, weekly for 4 weeks, then monthly for 2 months. Results of the audits will be reviewed at the Quality Assurance meeting for revisions as needed.</p> <p>V. Completion Date:</p>	5/28/10

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F 431	Continued From page 29 temperature and are to be accessible only to licensed nursing staff (including certified or qualified medication aides) and authorized personnel..." 2. Observations in hall 1 on 4/26/10 at 8:30 PM, revealed a vial of insulin was left unattended on top of hall 1 medication cart. During an interview in room 15 on 4/28/10 at 5:15 PM, Nurse #2 stated, "Didn't realize I left the insulin on top of the cart." 3. Observations in hall 1 on 4/27/10 at 8:35 AM, revealed Nurse #3 left a pouch of crushed Lortab unattended on top of hall 1 medication cart. Observations in hall 1 on 4/27/10 at 9:35 AM, revealed Nurse #3 left Multivitamin liquid and Dilantin suspension unattended on top of hall 1 medication cart. 4. Observations in hall 1 on 4/27/10 at 4:00 PM, revealed the hall 1 medication cart was left unattended, unlocked, and out of view of the nurse. The keys to the medication cart were laying on top of it.	F 431			
F 441 SS=F	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 -	F 441	F-441 Infection Control s/s=F I. The glucometer machine and blood pressure machine are being cleaned with resident use as per recommended guidelines. Staff is washing their hands when coming in direct contact with residents and washing their hands as per recommended guidelines. Staff is dispensing paper towels without touching their uniforms. The nurses are cleaning their scissors between use.		

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HEALTH CARE FACILITY FAX: (31-512-0063

May 10 2010 05:21pm P034/053
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F 441	<p>Continued From page 30</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observations and interviews, it was determined 6 of 6 nurses (Nurses #1, 2, 3, 4, 5 and 6); 1 of 7 Certified Nurse Technicians (CNT #1) and 1 of 1 housekeeping staff (Housekeeper #1) failed to ensure infection control practices were used to prevent the spread of infection by not cleaning the glucometer instrument between residents; not washing hands properly and/or not washing</p>	F 441	<p>II. Glucometers and blood pressure machines have been cleaned and are being cleaned between resident use as per recommended guidelines. Staff is washing their hands when in direct contact with residents and dispensing paper towels without touching their uniforms. Nurses are cleaning their scissors between use.</p> <p>III. Facility staff have been re-educated on hand washing requirements and completed a return demonstration. Staff has been re-educated on cleaning of medical equipment and supply distribution.</p> <p>IV. The Administrator, Director of Nursing and/or Designee will complete random audits of medical equipment cleaning, hand washing and supply distribution 3 times a week for 4 weeks, weekly for 4 weeks, then monthly for 3 months. Results of the audits will be reviewed at the Quality Assurance meeting for revisions as needed.</p> <p>V. Completion Date:</p>	5/28/10

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NAME OF PROVIDER OR SUPPLIER BELCOURT TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1710 BELCOURT AVENUE NASHVILLE, TN 37212		
(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	
F 441	<p>Continued From page 31</p> <p>hands between residents before handling food and failed to handle supplies to prevent contamination.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's "TRUEtrack QUALITY Assurance/Quality Control Manual" documented, "Meter [Glucometer]: Wipe meter with a clean, lint-free cloth dampened with mild detergent/soap. 10% [percent] household bleach and water, or OSHA [Occupational Safety Health Administration] approved disinfectant... Do not use alcohol to clean the meter. Cleaning the Meter with alcohol WILL cause damage..." 2. Review of the facility's "Wash Your Hands" policy documented, "...in healthcare settings, handwashing can prevent potentially fatal infections from spreading from patient to patient and from patient to healthcare worker and vice versa. The basic rule... is to cleanse hands before and after each patient contact by either washing hands or using an alcohol hand rub... Wash Your Hands: The Right Way: When washing hands with soap and water. Wet your hands with clean running water and apply soap. Use warm water if it is available. Rub hands together to make a lather and scrub all surfaces. Continue rubbing hands for 15- [to] 20 seconds... Rinse hands well under running water. Dry your hands using a paper towel or air dryer. If possible, use your paper towel to turn off the faucet..." 3. Observations on hall 1 on 4/26/10 at 8:30 PM, revealed Nurse #2 did not clean the glucometer machine prior to or after checking a resident's blood sugar. 	F 441			

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F 441	<p>Continued From page 32</p> <p>4. Observations on hall 2 on 4/27/10 at 11:45 AM, revealed Nurse #4 cleaned the glucometer machine with an alcohol wipe before and after checking a resident's blood sugar.</p> <p>During an interview at the nurse's station on 4/28/10 at 2:20 PM, Nurse #4 stated, "I thought the alcohol wipes were okay to clean the glucometer machine. The DON [Director of Nursing] told me today we're to use the sani-wipes."</p> <p>5. Observations on hall 2 on 4/27/10 at 8:10 AM, revealed Nurse #4 placed the blood pressure machine on a resident's bed. Nurse #4 dropped a glove on the floor, picked the glove up from the floor and applied another pair of gloves. Nurse #4 did not clean the blood pressure machine before or after checking the resident's blood pressure. Nurse #4 did not wash her hands or use hand sanitizer after picking an item up from the floor.</p> <p>During an interview at the nurse's station on 4/28/10 at 2:20 PM, Nurse #4 stated, "I shouldn't have put the blood pressure machine on the bed and should have cleaned it before and after using it."</p> <p>6. Observations on hall 2 on 4/27/10 at 5:13 PM, revealed Nurse #5 cleansed the glucometer with an alcohol wipe before and after checking a resident's blood sugar. Nurse #5 was observed to apply gloves, obtained an blood sugar, removed the gloves and then used hand sanitizer. Nurse #5 did not wash her hands with soap and water.</p> <p>During an interview in the DON's office on 4/28/10 at 11:15 AM, the DON stated, "They are to wash hands immediately after taking gloves off."</p>	F 441		

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F 441	Continued From page 33 7. Observations in Random Resident (RR) #1's room on 4/27/10 at 8:16 AM, Certified Nursing Technician (CNT) #1 picked up a floor mat and assisted pulling RR #1 up in the bed. CNT #1 did not wash her hands before she opened and touched the straw or picked up the biscuit with her bare hands. 8. Observations in the dining room on 4/27/10 at 8:25 AM, revealed Nurse #1 setup a breakfast tray, then touched the resident on the shoulder, went to a second resident and opened a straw and placed in her juice, then went to a third resident and picked up a biscuit from the plate with her bare hands and spread jelly on it. Nurse #1 did not wash her hands between residents. 9. Observations in hall #1 on 4/27/10 at 8:30 AM, revealed Housekeeper #1 held uncovered large rolls of paper towels under her arms, touching her uniform as she went into Room 18. 10. Observations in hall 1 on 4/27/10 beginning at 8:35 AM, revealed Nurse #3 washed her hands and turned the faucet off with her bare hands. Nurse #3 was observed to repeat this procedure of washing hands and turning the faucet off with her bare hands four times. 11. Observations in Resident #8's room on 4/27/10 at 8:52 AM, CNT #1 opened the window blinds and did not wash her hands before picking up the resident's biscuit with her bare hands. 12. Observations in the dining room on 4/27/10 at 12:30 PM, revealed Nurse #1 move a resident in a wheelchair, then went to the clean storage cabinet and got a clothing protector and placed it	F 441		

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F 441	Continued From page 34 on another resident, then went to the counter and got napkins to give to a third resident. Nurse #1 did not wash her hands after direct contact between residents. 13. Observations during a dressing change in Random Resident (RR) #6's room on 4/28/10 at 11:40 AM, revealed the Assistant Director of Nursing (ADON) (Nurse #8) removed a pair of scissors from her uniform pocket, placed the scissors on a towel on RR #6's bed. The ADON proceeded to use the scissors to cut the kerlix off RR #6's pressure ulcer. The ADON placed the scissors back on the towel on RR #6's bed and proceeded to use them to cut the Aquicel to place on RR #6's pressure ulcer. The ADON did not clean the scissors after using them to cut the soiled dressing off. Observations during the dressing change in RR #6's room on 4/28/10 at 11:40 AM, revealed Nurse #1 washed her hands and turned off the faucet with her bare hand. Nurse #1 repeated this procedure twice. During an interview on Hall 2 on 4/28/10 at 3:55 PM, the ADON stated, "I should have cleaned the scissors between use."	F 441			
F 498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced	F 498			

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F 498	<p>Continued From page 35</p> <p>by: Based on policy review, observations and interviews, it was determined the facility failed to ensure 1 of 3 Certified Nurse Technicians (CNA #2) demonstrated competency when pericare was performed.</p> <p>The findings included:</p> <p>Review of the facility's Perineal Care policy documented, "...(1) Separate labia... (2) Continue to wash the perineum moving outward to and including thighs..."</p> <p>Observations in Resident #2's room on 4/28/10 at 11:15 AM, revealed CNT #2 performed pericare on Resident #2. Resident #2 was positioned on her back. CNT #2 lowered the diaper in the front and performed pericare by cleaning the right groin in a downward motion front to back, changed the cloth and then repeated the same technique on the left groin. CNT #2 then cleaned the middle of Resident #2's vaginal area without separating the labia. CNT #2 then rinsed the areas and dried. CNT #2 then removed the gloves and did not wash her hands. CNT #2 then donned gloves and repositioned Resident #2 to her right side and removed the diaper. CNT #2 then removed gloves and discarded the gloves in the trash. CNT #2 did not wash her hands. CNT #2 then donned gloves and washed Resident #2's rectal area front to back, rinsed, and dried. CNT #2 then removed gloves, did not wash her hands and went to Resident #2's closet to get a clean diaper. CNT #2 donned gloves and placed a diaper on Resident #2. CNT #2 then proceeded to dress Resident #2. Nurse #1 observed the pericare procedure performed by CNT #2.</p>	F 498	<p>F-498 Nurse Aide Competency s/s=D</p> <ol style="list-style-type: none"> I. Resident #2 is receiving pericare as per recommended guidelines. II. Residents have been assessed and are receiving pericare as per recommended guidelines. III. Nursing assistants have been re-educated on guidelines for providing pericare. Nursing assistants have completed return demonstrations. IV. The Director of Nursing, Assistant Director of Nursing and/or Designee will complete random audits of staff providing pericare weekly for 4 weeks, then monthly for 3 months. Results of the audits will be reviewed at the Quality Assurance meeting for revisions as needed. V. Completion Date: 	5/28/10
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F 498	Continued From page 36 During an interview in room #5 on 4/28/10 at 2:10 PM, Nurse #1 was asked what procedure is expected when CNTs perform pericare. Nurse #1 stated, "She [CNT #2] didn't separate the labia like she should have to clean really good."	F 498			