

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1902	(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) COMPLETE DATE
N 629	<p>1200-8-6-.06(3)(b)8. Basic Services</p> <p>(3) Infection Control.</p> <p>8. Water pitchers, glasses, thermometers, emesis basins, douche apparatus, enema apparatus, urinals, mouthwash cups, bedpans and similar items of equipment coming into intimate contact with residents shall be disinfected or sterilized after each use unless individual equipment for each is provided and then sterilized or disinfected between residents and as often as necessary to maintain them in a clean and sanitary condition. Single use, resident disposable items are acceptable but shall not be reused.</p> <p>This Rule is not met as evidenced by: Type C Pending Civil Monetary Penalty #31</p> <p>1200-8-6-.06(3)(b)8. Tennessee Code Annotated. 68-11-804(c)31: All nursing homes shall disinfect contaminated articles and surfaces, such as mattresses, linens, thermometers and oxygen tents.</p> <p>This Rule is not met as evidenced by:</p> <p>Based on policy review, observations and interview, it was determined 2 of 6 nurses (Nurses #2 and 4) failed to ensure infection control practices were used to prevent the spread of infection by not cleaning a glucometer before and after use or failed to clean blood pressure equipment.</p> <p>The findings included:</p>	N 629	<p>N-629 Infection Control</p> <p>I. The glucometer machine and blood pressure machine are being cleaned with resident use as per recommended guidelines.</p> <p>II. Glucometers and blood pressure machines have been cleaned and are being cleaned between resident use as per recommended guidelines.</p> <p>III. Staff has been re-educated on cleaning of the glucometer machine and blood pressure machine as per recommended guidelines.</p> <p>IV. The Administrator, Director of Nursing and/or Designee will complete random audits of glucometer machine and blood pressure machine cleaning 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>	5/19/10

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Administrator

(X6) DATE

5/19/2010

STATE FORM

6899

OK8H11

If continuation sheet 1 of 10

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N 629	Continued From page 1 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. 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. 3. 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. 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 [accucheck] machine. The DON [Director of Nursing] told me today we're to use the sani-wipes." 4. 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 did not clean the blood pressure machine before or after checking the resident's blood pressure. 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."	N 629		

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N 728 N 728	Continued From page 2 1200-8-6-.06(6)(b) Basic Services (6) .Pharmaceutical Services. (b) Such cabinets or drug rooms shall be kept securely locked when not in use, and the key must be in the possession of the supervising nurse or other authorized persons. This Rule is not met as evidenced by: Type C Pending Penalty #7 1200-8-6-.06(6)(b) Tennessee Code Annotated 68-11-804(c)7: Such cabinets or drug rooms shall be securely locked when not in use, and the key must be in the possession of the supervising nurse or other authorized person on duty. This Rule is not met as evidenced by: Based on policy review, observations and an interview, it was determined the facility failed to ensure that 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. The findings included: 1. Review of the facility's medication storage documented, "POLICY: A. Medications are to be stored in a secure manner, under proper 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,	N 728 N 728	N-728 Pharmaceutical Services 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. II. Medication carts have been checked, they are being locked and the medication and keys are secured. III. Licensed nurses have been re-educated on securing the medications, medication cart and keys. 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. V. Completion Date:	

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N 728	Continued From page 3 revealed a vial of insulin was left unattended on top of the 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 the pouch of crushed Lortab unattended on top of the 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 the 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.	N 728		
N 767	1200-B-6-.06(9)(I) Basic Services (9) Food and Dietetic Services. (I) Food shall be protected from dust, flies, rodents, unnecessary handling, droplet infection, overhead leakage and other sources of contamination whether in storage or while being prepared and served and/or transported through hallways. This Rule is not met as evidenced by: Type C Pending Penalty #22	N 767		

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N 767	<p>Continued From page 4</p> <p>Tennessee Code Annotated 68-11-804(c)22: Food shall be protected from dust, flies, rodents, unnecessary handling, droplet infection, overhead leakage and other sources of contamination, whether in storage or while being prepared and served and/or transported through hallways.</p> <p>This Rule is not met as evidenced by:</p> <p>Based on 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, properly clean surfaces and equipment which could affect 37 of 39 residents residing in the facility.</p> <p>The findings included:</p> <p>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 dietary staff members were present during the tour of the kitchen.</p> <p>Observations during the initial tour of the kitchen on 4/26/10 beginning at 7:20 PM revealed the following:</p> <p>a. A mop in a bucket of dirty water in front of the Reach-In Freezer.</p> <p>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.</p> <p>c. The lid to the corn meal storage container was</p>	N 767	<p>N-767 Food and Dietetic Services</p> <p>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.</p>	

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N 767	<p>Continued From page 5</p> <p>partially covering the container.</p> <p>d. Three of four steam table pans had debris on them.</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 tour 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>	N 767	<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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N 767	<p>Continued From page 6</p> <p>During an interview in the kitchen on 4/26/10 beginning at 7:20 PM, the Cook stated, "Those 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>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. deli 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) 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</p>	N 767			

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N767	Continued From page 7 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.	N767		
N1216	1200-8-6-.12(1)(p) Resident Rights (1) The nursing home shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservation of dignity, individuality and, to the extent medically feasible, independence. Residents and their families or other representatives shall be fully informed and documentation shall be maintained in the resident 's file of the following rights: (p) To have their records kept confidential and private. Written consent by the resident must be obtained prior to release of information except to persons authorized by law. If the resident lacks capacity, written consent is required from the resident 's health care decision maker. The nursing home must have policies to govern access and duplication of the resident 's record; This Rule is not met as evidenced by: Type C Pending Penalty #5 1200-8-6-.12(1)(p) Tennessee Code Annotated 68-11-804(c)5: Each patient has a right to have the patient's personal records kept confidential and private. The nursing home must have policies to govern access and duplication of the patient's records. Except for those persons authorized by law to inspect such records, written consent by the	N1216		

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N1216	<p>Continued From page 8</p> <p>patient must be obtained before any information can be released. If the patient is mentally incompetent, written consent is required by the patient's legal representative.</p> <p>This Rule is not met as evidenced by:</p> <p>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> <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,</p>	N1216	<p>N-1216 Resident Rights</p> <p>I. Resident medical/medication information is being kept confidential. Resident #5 and Resident #6 are being provided cares in privacy.</p> <p>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.</p> <p>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.</p> <p>IV. The Administrator, Director of Nursing and/or Designee will complete random audits of medication carts and nursing units 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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N1216	<p>Continued From page 9</p> <p>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 #5'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 was left open and Resident #5's abdomen was visible to anyone who passed by.</p> <p>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.</p> <p>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]."</p>	N1216		