

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 05/22/2014
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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 246 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES SS=D F 246

A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review, observation and interview, it was determined the facility failed to place call lights within reach of 2 of 16 (Residents #21 and 24) sampled residents of the 33 residents included in the stage 2 review.

The findings included:

1. Review of the facility's "Call Lights" policy documented, "...The purpose of this procedure is to provide the resident with a means to request assistance... 1. Staff should explain to the resident... where it is located..."

2. Medical record review for Resident #21 documented an admission date of 6/20/12 and a readmit date of 5/14/13 with diagnoses of Psychosis, Upper Respiratory Disease, Nausea, Urinary Tract Infection, Mood Disorder, Diarrhea, Conjunctivitis, Dysphagia, Acute Bronchospasm, Ischemic Heart Disease, Depression, Anxiety, Constipation, Malnutrition, Eye problems, Esophageal Reflux, Dementia, Chronic Airway Obstruction, Atrial Fibrillation, Congestive Heart Failure, Legal Blindness, Muscle Weakness, Debility, Bacterial Pneumonia, Chronic Pain, *accident POC 6/13/14 JP PH/ML*

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.
This plan of correction constitutes our credible allegation of compliance.

RECEIVED

JUN 10 2014

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

TITLE

(X6) DATE

R.A. McK...

Administrator

06/06/2014

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.

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

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F 246 Continued From page 1
Hypertension, Nonorganic Psychosis and Lack of Coordination.

Observations in Resident #21's room on 5/19/14 at 10:05 AM, revealed Resident #21 resident's call light was not within Resident #21's reach and was clipped to the privacy curtain located at the foot of the bed.

During an interview in Resident #21's room on 5/19/14 at 10:50 AM, Resident #21 was asked if she could reach her call light. Resident #21 stated, "They [staff] don't like me to push the button and I will push it, and they will come in and hide it somewhere where I can't get to it. They [staff] do it [hide the call light] in the day and night time."

3. Medical record review for Resident #24 documented an admission date of 4/14/14 with diagnoses of Depression, Lower Leg Contracture, Chronic Pain, Muscle Weakness, Difficulty in Walking, Chronic Kidney Disease-Stage 3, Hyperlipidemia, Osteoarthritis, Cerebrovascular Disease, Hemiplegia-Non Dominant Side, Hypertension, Congestive Heart Failure, Chronic Airway Obstruction and Atrial Fibrillation.

Observations in Resident #24's room on 5/19/14 at 9:50 AM, revealed Resident #24's call light was not within Resident #21's reach. The call light was behind the bed on the floor.

During an interview in Resident #24's room on 5/19/14 at 1:52 PM, Resident #24 was asked if the call light was placed where she could reach it. Resident #24 stated, "Sometimes my call light is clipped to the curtain or on the floor."

F 246

- I. Resident #21 and resident #24 have their call light placed within reach.
- II. Residents have been checked and call lights are placed within reach.
- III. Nursing staff has been reeducated on placement of call lights. Department Managers have been educated on monitoring for placement during routine rounds.
- IV. The Director of Nursing, Administrator and / or designee will complete random audits of call light placement three times a week for four weeks, weekly for two months, then quarterly for two quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.
- V. Completion Date: June 10, 2014.

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F 246 Continued From page 2
During an interview in the Social Services office on 5/22/14 at 2:37 PM, the Director of Nursing (DON) was asked what her expectation of the placement of the residents' call lights were. The DON stated, "I expect them [staff] to clip them [call light] within reach of the resident."

F 246

F 253 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES
SS=D

F 253

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:
Based on observation, it was determined the facility failed to ensure the facility was clean and sanitary as evidenced by a dirty commode seat, and urine odors in 1 of 29 (Resident #35) resident's room and bathroom.

The findings included:

Observations in Resident #35's room and bathroom on 5/19/14 at 7:35 AM and on 5/20/14 at 11:15 AM, revealed urine odors in the room and bathroom and the elevated commode seat in the bathroom had a brown and yellow substance smeared on it.

F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
SS=G

F 309

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

- I. Resident #35's room and bathroom have been cleaned and are on a routine cleaning schedule.
- II. Resident rooms have been checked and are being cleaned per cleaning schedules.
- III. Housekeeping Supervisor, housekeeping staff and nursing staff have been reeducated on cleaning rooms and bathrooms, and monitoring for additional cleaning when needed.
- IV. The Housekeeping Supervisor, Administrator and / or designee will complete random audits of resident rooms / bathrooms for cleanliness and odors three times a week for four weeks, weekly for two months, then quarterly for two quarters. Results of the

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F 309 Continued From page 3 and plan of care.

F 309. audits will be reviewed at the Quality Assurance meetings for revisions as needed.

V. Completion Date: June 10, 2014

This REQUIREMENT is not met as evidenced by:
Based on policy review, review of a personnel file, medical record review, observation and interview, it was determined the facility failed to ensure pain was controlled during a dressing change for 1 of 2 (Resident #46) residents observed for dressing change in the stage 2 review. The facility failed to manage Resident #46's pain as evidenced by the resident grimacing and repeatedly crying "No. No." during a dressing change, which resulted in actual harm to Resident #46.

The findings included:

Review of the facility's Nursing Policy and Procedure Manual, revised April 2010, documented, "...The Lippincott Manual for Nursing is to be used as the reference guide for skilled nursing functions... require that you follow a basic nursing standard of practice. This practice includes following... providing for resident dignity... Staff will complete a pain assessment during the admission process, quarterly and with a significant change assessment... It is encouraged to have the licensed professional nurse check with the residents on a routine basis for any evidence of pain, and document the Treatment Administration Record (TAR) that they have done so... Education on pain management should be provided on a routine basis. A care plan will be initiated during the admission process to monitor for potential pain and/or for actual pain. This will assist the team in determining pain

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F 309 Continued From page 4
location, possible causes and intervention to reduce or alleviate pain..."

Medical record review for Resident #46 documented an admission date of 10/17/13 with diagnoses of Coronary Artery Disease, Senile Dementia with Delirium, Hyperlipidemia, Hypothyroidism, Altered Mental Status, Chronic Kidney Disease Stage 2, Difficulty in Walking, Alzheimer's Disease, Dementia with Behavior Disturbances, Encephalopathy, Diabetes, History of Breast Cancer with Mastectomy and Adult Failure to Thrive.

Review of a physician's order dated 4/23/14 documented, "Norco (acetaminophen - hydrocodone Schedule III tablet; 325 mg [milligrams] -5 mg; oral Once A Day-PRN [as needed] 30 minutes prior to wound tx [treatment]..." A physician order dated 5/6/14 documented, "...Norco (acetaminophen - hydrocodone)-Schedule III tablet: 325 mg -5 mg-oral Special Instructions: 30 minutes prior to wound tx Every 6 Hours - PRN.

Review of the pain assessments revealed there was one pain assessment completed on 5/6/14. There was no documentation of pain assessment on the Treatment Administration Records for April, 2014 through May 21, 2014 as per policy.

Review of April 2014 Medication Administration Record (MAR) documented no pain medication given on 4/28/14. Review of May 2014 MAR documented no pain medication given May 1 through 6 and May 11th.

Observations of a dressing change in Resident #46's room on 5/21/14 from 11:20 AM to 12:00

F 309

I. Resident #46 has been reassessed for pain management by nursing. Pain management is being completed under the direction of the attending physician and hospice services.

II. Residents have been reassessed for pain. Residents with wound treatments have been assessed for pain management needs prior to dressing changes.

III. Licensed nurses have been educated on Pain Management Program, notifying the physician if current pain regimen is not effective and pain management during wound treatments.

IV. The Director of Nursing and / or designee will complete random audits of pain management during wound treatments and pain assessments four times a week for four weeks, weekly for two months, then quarterly for two quarters. Results of the audits will be discussed at the Quality Assurance meeting for revisions as needed.

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PM revealed the following:
a. Nurse #2 positioned Resident #46 on the bed to start with the right foot wounds. Nurse #2 removed the old dressing that was noted to be saturated with brownish drainage on the inner dressing over the right heel. Resident #46 continually cried "No. No." and reached toward the nurse. Nurse #2 cleaned the wound on right outer foot area with derma clens, changed gloves, applied santyl to wound bed of the right outer foot and the right ankle wounds and placed an island dressing to cover the areas. Nurse #2 washed hands and changed gloves, cleaned right heel with dermaclens, changed gloves applied hydrogel to heel and covered the wound with a dressing and wrapped with kerlix, dated dressing, washed hands and changed gloves. Resident #46 cried "No. No. No." the entire time the Nurse #2 was cleaning, applying ointments and dressing the right foot wounds. Resident #46 would reach out toward the nurse and was observed to grimace and cry during the dressing change.

b. Nurse #2 the repositioned Resident #46 to do wound care on the right hip. Nurse #2 removed the old dressing from the right hip area as Resident #46 continually cried "No. No." Resident #46 was observed to guard her hip area with her right arm which resulted in Certified Nursing Technician (CNT) #1 having to hold Resident #46's hands to prevent Resident #46 from pushing the nurse away from the area. Resident #46 was observed to hold onto her pants to prevent the nurse from pulling them down to perform the wound care. Nurse #2 cleaned the area with dermaclens, changed gloves, applied medihoney and covered the wound with an island dressing and dated. Resident #46 continually cried "No. No.", guarded the area and grimaced

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F 309 Continued From page 6
during the wound care.

F 309

c. Nurse #2 positioned Resident #46 for wound care on the left hip. Resident #46 held onto the pants to prevent staff from pulling them down from the wound area. Nurse #2 cleaned area with dermaclens, applied medihoney and island dressing and dated the dressing. Resident #46 cried repeatedly "No. No." during the care. Resident #46 was observed to grimace and attempted to grab the nurse to prevent Nurse #2 from doing the wound care. CNT #1 held Resident #46's hands.

Observations of the wounds during the dressing change as noted above are as followed:

- a. Right outer lower foot wound - 2 by (x) 1 inch, center is brownish color with reddened edges, scant drainage noted.
- b. Right outer upper ankle wound - nickel sized, brownish red center, no drainage noted.
- c. Right Heel wound - 3x3x1/2 inches, there is a half dollar sized piece of brown/black tissue material hanging by a small area at the edge of wound from the wound, the center of the wound had thick, tan drainage large amount causing old dressing to be saturated, wound had foul odor.
- d. Right Hip - 3x3x1/4 inches total with an area at 12 o'clock approximately 1x1/2 inch that is black, another area at 6 o'clock approximately 1/2 x1/2 inch that is black. Remaining area of wound bed was brown/yellowish moist, edges red.
- e. Left Hip - 2 1/2 x 2 1/2 inches, center is black, dry, edges moist and red.

During an interview in Resident #46's room while preparing for the dressing change on 5/21/14 at 11:20 AM, Nurse #2 stated, "...[Resident #46] cries when we change her dressings, she asks

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why, cries repeatedly from pain, she has been medicated this morning at 8:30 AM, the family allows a pain pill daily before treatments only. The doctor is aware of the pain but cannot give anything due to family, family has been made aware of her pain but only allows pain pill with dressing change..."

During an interview in the Social Service office on 5/21/14 at 3:10 PM, the Director of Nursing (DON) was asked about pain control for Resident #46. The DON stated, "[Resident #46] was showing pain when put on Lortab, but not in the kind of pain I saw this morning... dressing came off [Resident #46]'s right foot and I redressed it I saw she needed something stronger..."

During an interview in the front lobby on 5/22/14 at 7:15 AM, CNT #1 was asked about Resident #46. CNT #1 stated, "Been having pain like that for about 2 months."

Review of Nurse #2 personal file documented date of Hire 4/4/14, has a multistate active license with original issue date of 3/24/14, and orientation/competency checklist dated 4/4/14 documented Nurse #2 had been checked off for Pain Management.

The failure of the facility to assess for and manage pain resulting in actual harm to Resident #46.

F 312 483.25(a)(3) ADL CARE PROVIDED FOR F 312
SS=D DEPENDENT RESIDENTS

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal

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F 312 Continued From page 8 and oral hygiene.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review, observation and interview, it was determined the facility failed to provide nail care for 1 of 16 (Resident #4) residents of the 33 residents included in the stage 2 review.

The findings included:

Review of facility's residents' rights policy documented, "...33. The Resident has the right to reasonable accommodation of individual needs..."

Medical record review for Resident #4 documented an admission date of 3/11/11 with diagnoses of Urinary Tract Infection, Nausea and Vomiting, Candidiasis - Vulva, Tuberculosis Suspected (positive TB Skin test), Diarrhea, Pulmonary Congestion, Convulsions, Acute Ear Infection, Acute Pain, Depression, Hypertension, Post Traumatic Seizures, Glaucoma, Cerebral Artery Occlusion with Infarction, Cerebral Vascular Accident (CVA) Osteoarthritis, Left Sided Hemiplegia, Symbolic Symptom Dysfunction and Muscle weakness.

Review of a care plan dated 3/11/12 and updated on 5/5/14 documented, "...REQUIRES ASSISTANCE WITH ADL [activity's of daily living] CARE R/T [related to] CVA with chronic left side weakness... Resident prefers long nails... Approaches include... ASSIST WITH... PERSONAL HYGIENE..."

F 312

- I. Resident #4 has received nail care assistance.
- II. Residents have been checked and nail care assistance has been provided where needed.
- III. Nursing staff has been reeducated on assisting residents with nail care.
- IV. The Director of Nursing and / or designee will complete random audits of nail care three times a week for four weeks, weekly for two months, then quarterly for two quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.
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Observations in the dining room on 5/19/14 at 2:15 PM, revealed Resident #4's fingernails were dirty.

Observations in Resident #4's room on 5/20/14 at 11:40 AM, revealed Resident #4's fingernails were dirty.

Observations in the dining room on 5/20/14 at 6:10 PM, revealed Resident #4 eating dinner with dirty fingernails.

Observations in Resident #4's room on 5/22/14 at 9:53 AM, revealed Resident #4's finger nails were dirty.

During an interview in Resident #4's room on 5/20/14 at 11:40 AM, Resident #4 was asked if she would like her finger nails cleaned. Resident #4 stated, "Yes, but they don't clean them and I don't ask them to clean them."

During an interview in the Director of Nursing's (DON) office on 5/22/14 at 12:22 PM, the DON was asked what she expected the staff to do when a resident had dirty fingernails. The DON stated, "I expect them [staff] to clean dirty fingernails."

F 312

F 371 483.35(i) FOOD PROCURE,
SS=E STORE/PREPARE/SERVE - SANITARY

F 371:

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

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This REQUIREMENT is not met as evidenced by:

Based on review of the facility's "Fundamentals of Standard Precautions", review of the kitchen cleaning schedule, observation and interview, it was determined the facility staff failed to wash their hands and handled food with their bare hands during 2 of 2 (5/19/14 and 5/21/14) dining observations. The facility failed to ensure food was protected from sources of contamination as evidenced by the stove and oven were dirty, food was not labeled and dated and staff failed to wear a beard cover and hair was not completely covered.

The findings included:

1. Review of the facility's "Fundamentals of Standard Precautions" documented, "...Hand Hygiene is the single-most important measure to reduce the risk of transmitting microorganisms... Cleaning hands with soap, warm water, and friction for 15 seconds or alcohol-based waterless hand rubs as promptly and thoroughly as possible between patient contacts; after contact with... contaminated equipment or articles; and after gloves are removed is vital for infection control... Wearing gloves does not replace the need for hand hygiene because gloves may have small defects or may be torn during use, and hands can become contaminated from those leaks. Also, during the removal of gloves hands may become contaminated..."

a. Observations of breakfast tray service on Unit

F 371

I. Certified Nursing Technicians #2 and #3 are using gloves when touching any food items, washing hands after glove removal and between resident contact when assisting with meals.

The oven, grease trap and stove have been cleaned. The dietary hand sink has been replaced. The large trash can has been cleaned inside and out. Cherry pie, pound cake, apple-sauce, container of peaches, salami slices, shrimp poppers and bag of fish filets were discarded.

Dietary Manager is using a beard guard as needed and a hairnet that covers hair when in the kitchen area.

II. Certified Nursing Technicians are being observed and are using gloves when touching food items and washing hands per procedure. kitchen has been checked for cleaning and

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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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1 and Unit 2 on 5/19/14 beginning at 8:04 AM, revealed Certified Nursing Technician (CNT) #2 removed a meal tray from the hall cart, entered a resident's room, set up the tray for the resident, picked up the resident's toast with her bare hands, spreading it with the butter and jelly, and served it to the resident. CNT #2 applied hand gel and returned to the hall cart, removed a tray and served the next resident, placing the tray on the over-bed-table, applied gloves, repositioned the resident in the bed, removed the gloves, washed hands in the resident's bathroom, turning the water faucet off with bare hands re-contaminating her hands. CNT #2 returned to the hall cart, took out the next resident's tray, entered the resident's room, picked up the resident's toast with her bare hands, spreading it with the butter and jelly and served it to the resident. CNT #2 applied hand gel and returned to the cart, removed the next tray, entered the resident's room, applied gloves, repositioned the resident, washed her hands in the resident's bathroom, and turned the water faucet off with bare hands re-contaminating her hands. CNT #2 then completed setting up the resident's tray, picking up the toast with bare hands and spreading it with butter and jelly and served it to the resident.

b. Observations in the dining room on 5/19/14 beginning at 8:15 AM, Nurse #2 cut up food on one resident's tray and returned and finished feeding other resident and without washing hands between. After Nurse #2 finished feeding the resident Nurse #2 took an empty plate to the kitchen, received and sat clean cups in the coffee area, got milk and brought it to a resident, went back to the coffee area and prepared a cup of coffee for a resident and without washing her hands.

F 371 equipment has been cleaned. Food items in refrigerators and freezer have been checked and open food items are dated.
Dietary staff is being observed using beard guards as needed and hair coverings when in the kitchen area.
III. Nursing staff has been reeducated on handling food items for residents, glove use and hand washing procedures, with return demonstration.
The dietary staff and dietary manager have been reeducated on cleaning procedures and use of beard guards and hair covering when in the kitchen area.
IV. The Director of Nursing and / or Designee will complete random audits of nursing tray service three times a week for four weeks, weekly for two months then quarterly for two quarters. Results of the audits will be discussed at the Quality Assurance meetings

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c. Observations in the dining room on 5/21/14 at 12:30 PM, CNT #3 touched a resident's shoulder, moved a wheelchair and touched the end of the eating utensil, then went to the next resident, touched the resident on the shoulder, pulled the resident up in the chair and began to feed the resident without washing her hands.

2. Review of the kitchen cleaning schedule dated 5/18/14 (the day before surveyors entered) revealed the kitchen staff had signed off that the stove and kitchen had been cleaned.

Observations in the kitchen on 5/19/14 at 5:45 AM revealed the following:

- a. The oven and grease trap were black and coated with food debris.
- b. The stove was greasy with yellow grease and had food debris
- c. The hand sink was dirty.
- d. The large trash can beside freezer was dirty on inside and out.
- e. Refrigerator #1 contained - a tray containing 8 pieces of cherry pie and 5 pieces of pound cake and 1 bowl of applesauce with no label or date.
- f. Refrigerator #2 contained - a bowl of applesauce dated 5/15/14, a package of white cheese and a container of peaches with no label or date and a zip locked bag of Salami dated 5/16/14.
- g. Reach in Freezer contained - an opened bag of shrimp poppers and an opened bag of fish filet with no date.

Observations in the kitchen on 5/19/14 at 7:50 AM, the Dietary Manager (DM) was not wearing a beard cover and did not have hair completely covered at the back of the head.

F 371 for revisions as needed. The Dietician, Administrator, Dietary Manager and / or designee will complete random audits of cleaning procedures, dating opened food items, and use of beard guards and hair coverings three times a week for four weeks, weekly for two months, then quarterly for two quarters. Results of the audits will be discussed at the Quality Assurance meetings for revisions as needed.

V. Completion Date: June 10, 2014

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Observations in the kitchen on 5/20/14 at 9:05 AM revealed the following:
a. The same zip locked bag of Salami dated 5/16/14 was still in the refrigerator #2.
b. The DM's hair was not completely covered at the back of the head.

During an interview on 5/20/14 at 9:10 AM, the DM was asked about cleaning of the kitchen. the DM stated, "We do have a cleaning schedule and unless marked differently everything is done daily on the sheet."

F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS
SS=E

F 441

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 -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

- (b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a

- I. Nurses #1, #2, and #3 are washing their hands per hand washing procedures and glove use. Nurse #2 is disposing bagged soiled dressings in the biohazard room.
- II. Licensed nurses are being observed and washing hands per hand washing procedure, glove use and disposing bagged soiled dressings in the biohazard room.
- III. Licensed nurses have been reeducated on disposing of soiled dressings, hand washing procedures with return demonstration, and glove use.

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communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(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.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on review of the facility's "Fundamentals of Standard Precautions" policy, observation and interview, it was determined the facility failed to ensure 3 of 4 (Nurse #1, 2 and 3) nurses followed appropriate infection control practices to prevent cross contamination between residents during medication administration, and 1 of 2 (Nurse #2) nurses failed to ensure soiled dressings were disposed of properly following a dressing change.

The findings included:

1. Review of the facility's "Fundamentals of Standard Precautions" policy documented, "...Hand Hygiene is the single-most important measure to reduce the risk of transmitting microorganisms... Cleaning hands with soap, warm water, and friction for 15 seconds or alcohol-based waterless hand rubs as promptly and thoroughly as possible between patient contacts; after contact with... contaminated equipment or articles; and after gloves are

F 441 IV. The Director of Nursing and / or Designee will complete random audits of hand washing, glove use and disposal of soiled dressings three times a week for four weeks, weekly for two months, then quarterly for two quarters. Results of the audits will be discussed at the Quality Assurance meetings for revisions as needed.

V. Completion Date: June 10, 2014

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removed is vital for infection control... Wearing gloves does not replace the need for hand hygiene because gloves may have small defects or may be torn during use, and hands can become contaminated from those leaks. Also, during the removal of gloves hands may become contaminated..."

2. Observations during medication administration on 5/19/14 beginning at 5:56 AM, Nurse #1 applied gloves, prepared the resident's medication, administered the medication, removed the gloves, went to the refrigerator in the nourishment room down the hall, obtained a box of thickened drink, returned to the medication cart and signed off the medication on the medication administration record (MAR). At 6:02 AM, Nurse #1 applied gloves, prepared the next resident's medication, and attempted to administer the medication to the resident. The resident refused to take the medication. Nurse #1 removed the gloves, went back to the medication cart, applied a new pair of gloves prepared medication for the next resident and administered the medication to the resident. After Nurse #1 returned to the medication cart at 6:11 AM, the nurse was called back down the hall by a laboratory technician, spoke with the technician, returned to the nurses station, drank from a bottle of soda, returned to the medication cart, applied gloves, prepared medication for the next resident, and administered the medication to the resident. Nurse #1 removed her gloves, returned to the medication cart and a 6:15 AM, applied a new pair of gloves and began preparing the next resident's medication. Nurse #1 was not observed to wash her hands or applying hand gel at any time during the medication pass observations.

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Observations during medication administration on 5/22/14 at 9:57 AM, Nurse #1 applied gloves, prepared the resident's medication, removed the gloves, went to retrieve a blood pressure cuff, entered the resident's room, applied gloves, and obtained the prepared medication, and administered the medication to the resident. Nurse #1 was not observed to perform hand hygiene between glove changes.

3. Observations during medication administration on 5/20/14 at 12:15 PM, Nurse #2 entered the resident's room, washed her hands in the resident's bathroom, and re-contaminated her hands when she turned off the water faucet with her bare hands. Nurse #2 applied new gloves and completed the accucheck. Nurse #2 returned to the medication cart, removed the gloves, and cleaned the glucometer, returned the supplies to the medication cart drawer and signed off the accucheck on the MAR. Nurse #2 was not observed washing her hands or applying hand gel after removing her gloves.

Observations during medication administration on 5/21/14 at 12:40 PM, Nurse #2 completed an accucheck in a resident's room. Nurse #2 entered the resident's bathroom and washed her hands and re-contaminated her hands when she turned the water faucet off with bare hands. Nurse #2 returned to the medication cart, prepared the insulin, returned to the resident's room, washed her hands in the resident's bathroom and re-contaminated her hands when she turned the water faucet off with bare hands. Nurse #2 returned to the medication cart and signed off the medication on the MAR.

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F 441

4. Observations during medication administration on 5/20/14 at 5:03 PM, Nurse #3 gathered the supplies to perform an accucheck, entered the resident's room, and washed her hands in the resident's bathroom and re-contaminated her hands when she turned the water faucet off with bare hands. Nurse #3 used a Sani-cloth bleach wipe to clean the glucometer, placed the glucometer on a barrier on the resident's over-bed table, applied gloves, performed the accucheck removed the gloves, and returned to the medication cart. Nurse #3 signed off the accucheck on the MAR. Nurse #3 was not observed to wash her hands or use hand gel after removing her gloves. Nurse #3 gathered medication for the next resident, entered the resident's room, and washed her hands in the resident's bathroom and re-contaminated her hands when she turned the water faucet off with bare hands. Nurse #3 applied new gloves, checked the resident's peg tube placement and residual, administered the medication, removed the gloves, washed hands in the resident's bathroom, and re-contaminated her hands when she turned the water off with bare hands.

5. During an interview in the Director of Nursing's (DON) office on 5/22/14 at 2:30 PM, the DON was asked when the nurses were expected to perform hand hygiene. The DON stated, "We was our hands after we use gloves period."

6. Observations of dressing change in Resident #46's room on 5/21/14 beginning at 11:20 PM, Nurse #2 removed an old dressing saturated with brownish drainage from right foot, removed an old dressing from the right hip, and removed a dressing from the left hip. Nurse #2 gathered all soiled items and placed them in a clear plastic

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bag and discarded the bag into the regular trash bin located in the hallway.

F 441

During a interview at the nurses' station on 5/22/14 at 2:28 PM, Nurse #3 was asked where do you discard dirty dressings. Nurse #3 stated, "Biohazard room."

F 465 483.70(h)
SS=D SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON

F 465

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:
Based on observation, it was determined the facility failed to maintain a clean and sanitary environment at the front entrance, on 1 of 2 (Unit 1) halls and in 1 of 2 (Unit 1 shower room) resident shower rooms.

The findings included:

1. Observations of the front entrance and down the Unit 1 hall on 5/19/14 at 5:00 AM, revealed the presence of a stale urine odor.
2. Observations in Unit 1 shower room on on 5/20/14 at 11:25 AM, revealed the presence of a stale urine odor.

- I. The Unit 1 shower room has been cleaned.
- II. Shower rooms have been checked and have been cleaned.
- III. Housekeeping staff has been re-educated on cleaning procedures for shower rooms.
- IV. The Housekeeping Supervisor, Administrator and / or designee will complete random audits of the shower rooms for odors three times a week for four weeks, weekly for two months, then quarterly for two quarters. Results of the audits will be discussed at the Quality Assurance meetings forevisions as needed.
- V. Completion Date: June 10, 2014.

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