

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

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This plan of corrections is a requirement of federal law, but not necessarily an acknowledgement of any violation of federal laws and regulations

PRINTED: 12/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/18/2013
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NAME OF PROVIDER OR SUPPLIER BORDEAUX LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218
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F 159 483.10(c)(2)-(5) FACILITY MANAGEMENT OF
SS=D PERSONAL FUNDS

Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.

The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the

F 159 F159

- A. Beginning the weekend of January 11, 2014, spending money will be available on weekends (Saturday and Sunday) for residents between the hours of 10 a.m. and 12 noon. Residents will contact Nursing Supervisor to request spending money by calling the Information Desk and being transferred to the Nursing Supervisor.
- B. Nursing Supervisor looks up the resident's account on report provided to ensure there is money available to withdraw and to be sure there are no "special comments/notes" on the account limiting the funds to be dispersed.
- C. Provided there are adequate funds, Nursing Supervisor completes the Signatures for Weekend Spending Money Form by writing resident's name, amount of cash to be given, date and the resident signs. In the event the resident is unable to sign, the nursing supervisor must sign resident's name/by their name, have it witness and the resident is given the withdrawal amount. (See Attachment A)

1/18/14

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

[Handwritten Signature]

TITLE

Administrator

(X6) DATE

1/9/14

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 159 Continued From page 1
SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:
Based on interview, it was determined the facility failed to ensure residents had access to petty cash when requested on an ongoing basis for 2 of 3 (Residents #60 and Resident #141) sampled residents interviewed with a personal funds account of the 47 residents included in the stage 2 review.

- The findings included:
1. During an interview in Resident's #60's room on 12/16/13 at 4:21 PM, Resident #60 was asked, "Can you get your money when you need it, including on weekend?" Resident #60 stated, "No, closed on weekend..."
 2. During an interview in Resident #141's room on 12/16/13 at 3:46 PM, Resident #141 was asked, "Can you get your money when you need it, including on weekend?" Resident #141 stated, "No one here on weekend to give out money..."
 3. During an interview in the mini conference room on 12/18/13 at 2:05 PM, the Patient Account Specialist was asked what the hours of operation were and the days of week the office was open for residents to request money from their account. The Patient Account Specialist stated, "7:30 AM til [until] 4:00 PM, Monday

F 159
To ensure residents available balance, the staff should write beside the computer generated balance the amount and date the resident received.

Each shift must count and record all funds given and balance of funds in cash bag for a total of \$200.00. Each staff member is responsible for ensuring the monies are balanced each shift.

Staff is to complete a separate "Cash Balance Sheet" at the beginning and end of each shift and it should be signed by both the outgoing Nursing Supervisor and the incoming Nursing Supervisor. (See Attachment B)

On the next business day (normally Monday morning), each Cash Balance Sheet for each Nursing Supervisor and the printed fund balance reports along with remaining funds bag will be counted by Accounts and Records Management staff and signed by the Patient Accounts Specialist.

All weekend information will be maintained on file in Accounts and Records Management.

1/18/14

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F 159	<p>Continued From page 1</p> <p>SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, it was determined the facility failed to ensure residents had access to petty cash when requested on an ongoing basis for 2 of 3 (Residents #60 and Resident #141) sampled residents interviewed with a personal funds account of the 47 residents included in the stage 2 review.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. During an interview in Resident's #60's room on 12/16/13 at 4:21 PM, Resident #60 was asked, "Can you get your money when you need it, including on weekend?" Resident #60 stated, "No, closed on weekend..." 2. During an interview in Resident #141's room on 12/16/13 at 3:46 PM, Resident #141 was asked, "Can you get your money when you need it, including on weekend?" Resident #141 stated, "No one here on weekend to give out money..." 3. During an interview in the mini conference room on 12/18/13 at 2:05 PM, the Patient Account Specialist was asked what the hours of operation were and the days of week the office was open for residents to request money from their account. The Patient Account Specialist stated, "7:30 AM til [until] 4:00 PM, Monday 	F 159	<p>Residents and Responsible Parties will be notified of spending money being available on weekends by a Sign posted outside of Accounts and Records Management Cashier Window, a Letter being included in the Quarterly Statements and in Family and Resident Council meetings during the month of January and February.</p> <p>D. The Accounts and Records Manager or designee will audit 20% of residents with trust fund accounts to determine the availability of their funds on weekends for three months. When 95% of compliance has been reached for 3 consecutive months, audits will be conducted at the discretion of the Accounts and Records Manager or Director of Quality/Risk Management. Audit results will be reported monthly in Quality Council Committee by the Accounts and Records Manager or designee.</p>	

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F 241	Continued From page 3 During an interview on Birmingham 3 in the Patient Care Manager's office on 12/18/13 at 2:51 PM, Nurse #3 was asked how milk should be served. Nurse #3 stated, "Expect them [staff] to serve milk in a glass..." 2. Observations during dining on Birmingham 3 west hall on 12/16/13 at 12:31 PM, revealed certified nursing assistant (CNA) #1 stood over Resident #9 while feeding him. During an interview on Birmingham 2 in the Patient Care Manager's office on 12/18/13 at 2:41 PM, Nurse #2 was asked how staff should assist residents to eat. Nurse #2 stated, "...[staff] Should be at eye level. Most of them would be sitting..." During an interview on Birmingham 3 in the Patient Care Manager's office on 12/18/13 at 2:51 PM, Nurse #3 was asked how staff should assist residents to eat. Nurse #3 stated, "...[staff] would be sitting facing the resident [when assisting to eat]..."	F 241			
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 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. 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	F 280	F-Tag 280- 1, 2&3 A. Resident # 180 had a fall on November 25, 2013 care plan has been reviewed and updated with new intervention. (See Attachment E) For Resident #242 the care plan dated September 11, 2013 was reviewed along with documentation and was corrected to reflect resident is occasionally incontinent of Bladder/bowel. The care plan has been corrected to reflect bladder status. (See Attachment F).		1/18/14

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F 280	<p>Continued From page 4</p> <p>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 policy review, medical record review, observation and interview, it was determined the facility failed to update and revise the care plans related to falls and/or urinary catheters for 3 of 47 (Residents #180, 242 and 268) sampled residents included in the stage 2 review.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's care plan policy documented, "... Care Plans are to be updated as needed... to include new... interventions..." 2. Medical record review for Resident #180 documented an admission date of 12/22/11 with diagnoses of Alzheimer's Disease, Dementia, Chronic Paranoid Psychosis, Benign Prostatic Hypertrophy, Hypertension, Ischemic Heart Disease, Atrial Flutter, Debility, Esophageal reflux disease, Anxiety and Depression. Review of the fall event assessment dated 11/25/13 at 11:15 AM documented, "...housekeeping staff found lying on floor beside bed... New Intervention... Encourage resident to call for assistance..." The care plan dated 11/4/13 was not updated to include the new intervention implemented for the 	F 280	<p>Resident # 268 had an order for a Foley catheter that had not been care planned. Physician was contacted regarding Foley catheter. Physician orders were received on December 16, 2013 to discontinue the Foley catheter. The resident's care plan has been updated to reflect resident's current bladder status. (See Attachment G)</p> <p>B. Beginning December 19, 2013, all care plans were audited by Resident Assessment Manager and Restorative care Nurse for continent status care plans and falls care plans. Any deficiencies found were corrected.</p> <p>PCM, Charge Nurse and Medical Data Specialist, licensed nurses will in-serviced regarding care plan updates for Foley catheter orders and interventions for falls by January 17, 2014. (See Attachment H, I, J, K)</p> <p>C. Beginning on December 20, 2013 residents that have received an order for a Foley catheter will have their new order placed on the Electronic medication record. The new order will be presented during morning rounds occurring three (3) times a week. The Unit Charge Nurse or PCM will communicate the new orders related to Foley catheter to ensure it is addressed and appropriately added to the resident's care plan</p>	1/18/14

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F 280	<p>Continued From page 5 fall on 11/25/13.</p> <p>During an interview in the Director of Nursing's (DON) office on 12/18/13 at 10:35 AM, the DON was asked would it be expected to add new fall interventions to the care plan. The DON stated, "...I would expect it to be put on the care plan..."</p> <p>2. Medical record review for Resident #242 documented an admission date of 8/23/13 with diagnoses of Postoperative Respiratory Failure, Restrictive Lung Disease, Obesity, Obstructive Sleep Apnea, Right Hemidiaphragm Dysfunction, Hypertension, Atrial Fibrillation, Congestive Heart Failure, Tracheostomy, Malnutrition and Debility. Review of the care plan for Resident #242 dated 9/11/13 documented, "...INCONTINENCE... Resident occasionally incontinent with bladder/bowel..." Review of the quarterly Minimum Data Set (MDS) dated 11/27/13 documented Resident #242 was always incontinent of bladder and bowel. the care plan was not updated to reflect that Resident #242 is always incontinent.</p> <p>During an interview at Birmingham 2 nurses' station on 12/18/13 at 9:45 AM, Nurse #2 was asked should there be a care plan for always incontinent. Nurse #2 stated, "Yes."</p> <p>3. Medical record review for Resident #268 with an admission date 12/9/13 with diagnoses Anoxic brain damage, Pulmonary insufficiency following cardiac arrest, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Ischemic heart disease, Hypertension, Anemia, Diabetes Mellitus, Diabetic neuropathy, Debility, Dysphagia, Severe protein malnutrition, Gastroparesis, Gastrostomy, Barrett's</p>	F 280	<p>Beginning December 23, 2013 all nursing staff will be educated on the completion of the Admission Audit Tool (See Attachment L). With completion date for in-service as January 17, 2014. The nurse on duty at the time of admission and the nurse that follows will both sign the audit tool. All items on the audit, including Presence of Foley, Justification order, and size will be completed. This will be turned in to the Charge Nurse who will sign off on it and then give it to the PCM</p> <p>Learning Objectives:</p> <ul style="list-style-type: none"> • Understanding the review of care Plan to ensure it has been appropriately updated with Foley catheter orders/Continence status • Licensed nursing staff will understand that new Foley catheters must be added to care Plans <p>D. The Restorative Care Nurse, Resident Assessment Manager, PCM, Nursing Supervisor, DON or Director of Quality/Risk Management will audit:</p> <ol style="list-style-type: none"> a) All residents who have Foley catheters to ensure there is a correct care plan has been performed. (See Attachment M) b) All residents continence states to has been care planned.(See Attachment N) c) All residents who have had a fall to ensure they are updated with new interventions. (See Attachment O) <p>The threshold for audits compliance for the Quality Improvement process will be set at 95%. Once the threshold has been met for three (3) consecutive months, audits will be conducted as the discretion of the DON or Director of Quality/Risk Management. Audit results will be reported in monthly Quality Council Committee.</p>	1/18/14

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F 280	<p>Continued From page 6</p> <p>esophagus, Hiatal hernia, Anxiety, Thrombocytosis, Tracheostomy, history of coccyx fracture, Urinary devices, Vascular catheter and acute respiratory infections. The entry MDS dated 12/9/13 had no documentation for bladder incontinence. The admission physician's orders dated 12/9/13 had no documentation for use of a Foley catheter. The "New Admission Orders / Interim Plan of Care" dated 12/9/13 had no documentation under the catheter care section.</p> <p>Review of the interdisciplinary progress notes documented the following:</p> <p>a. 12/9/13 - "...foley patent draining yellow urine..."</p> <p>b. 12/11/13 - "...foley draining scant amount of yellow urine to bedside bag..."</p> <p>Review of the care plan dated 12/10/13 had no documentation for urinary continence or the use of the Foley catheter.</p> <p>Review of the physician's orders dated 12/16/13 documented, "1. D/C [discontinue] Foley..."</p> <p>Observations in Resident #268's room on 12/16/13 at 5:42 PM, revealed Resident #268 lying in bed with the Foley catheter in privacy bag.</p> <p>Observations in Resident #268's room on 12/17/13 at 8:09 AM, revealed Resident #268 did not have a Foley catheter.</p> <p>During an interview at the Birmingham 2 nurses' station on 12/18/13 at 2:20 PM, Nurse #2 was asked about the documentation for a Foley on the new admission orders / interim care plan. Nurse #2 stated, "...that is an oversight, in this box should have checked keep Foley in or D/C Foley</p>	F 280		
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<p>F 280</p> <p>F 315</p> <p>SS=D</p>	<p>Continued From page 7 on admission..."</p> <p>483.25(d) NO CATHETER, PREVENT UTI, 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 medical record review, observation and interview, it was determined the facility failed to obtain an appropriate diagnoses for the use of a Foley catheter and/or did not provide bowel and bladder training for 2 of 47 (Residents #54 and 242) sampled residents included in the stage 2 review.</p> <p>The findings included:</p> <p>1. Medical record review for Resident #54 with an admission date 11/19/13 with diagnoses Anemia, Coronary Artery Disease, Hypertension, Gastroesophageal Reflux Disease, Pneumonia, Diabetes Mellitus, Hyperlipidemia, Arthritis, Seizure Disorder, Depression, Respiratory Failure, Chronic Obstructive Pulmonary Disease, Osteoarthritis and Feeding difficulties. Review of the physician's orders dated 11/19/13 documented, "...Indwelling Foley Catheter Size #</p>	<p>F 280</p> <p>F 315</p>	<p>F-Tag 315</p> <p>A. For Resident #242 The Resident's Care Plan problem stated Incontinence- occasionally incontinent while the MDS 3.0 stated "always Incontinent" The care plan has been corrected to reflect bladder status (See Attachment P). The upcoming MDS 3.0 (February) will reflect continent status.</p> <p>On January 7, 2014 Incontinent Assessment B 645.0904 was performed (See Attachment Q) and plan of care was updated for resident. Resident will be trialed in a Toileting program beginning January 7, 2014, Resident Care Plan updated to reflect change</p> <p>For Resident #54 The Medical staff was contacted regarding the Foley catheter and verbal Physician's Orders were received on December 19, 2013 to discontinue the Foley catheter. The Foley catheter was removed by the staff nurse. Care plan was updated to reflect "Incontinence" (See Attachment R)</p> <p>B. Beginning December 23, 2013, all residents with a Foley catheter were audited to determine if an appropriate diagnosis was given for the instillation of the Foley Catheter. All Foley catheters without appropriate diagnosis were discontinued or a new diagnosis was obtained. All care plans were updated to remove "Incontinence/Foley" to reflect only one type of continence.</p>	<p>1/18/14</p>
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F 315 : Continued From page 8
(16 f [french] /10ml [milliliter]) change (Q [every] 30 Days & [and] PRN [as needed]) (DX [diagnosis]: SACRAL EXCORIATION...)

Review of the admission minimum data set (MDS) dated 11/23/13 documented, Resident #54 had an indwelling catheter and urinary continence was not rated.

Review of the care plan dated 11/25/13 documented, "...INCONTINENCE / INDWELLING CATHETER: She has a 16F/10ml indwelling catheter intact / patent to BSD [bedside drainage] d/t [due to] sacral excoriation..."

Observations in Resident #54's room on 12/18/13 at 11:10 AM, revealed Resident #54 with a Foley catheter in privacy bag.

During an interview at the Birmingham 2 nurses' station on 12/18/13 at 2:10 PM, Nurse #2 was asked if sacral excoriation is a proper diagnoses for a Foley. Nurse #2 stated, "No."

2. Medical record review for Resident #242 documented an admission date of 8/23/13 with diagnoses of Postoperative Respiratory Failure, Restrictive Lung Disease, Obesity, Atrial Fibrillation, Right Hemidiaphragm Dysfunction, Obstructive Sleep Apnea, Hypertension, Congestive Heart Failure, Tracheostomy, Malnutrition and Debility. Review of the interdisciplinary progress notes dated 8/28/13 at 4:30 PM documented, "...cont. [continent] of B&B [bowel and bladder]. Urinal provided 350 cc [cubic centimeters] clear yellow urine noted..." Review of section H of Resident #242's MDS dated 9/4/13 documented Resident #242 was occasionally incontinent. Review of the care plan dated

F 315

Residents will have a continence assessment B645.0904 (See Attachment S) completed upon admission to determine their continence level and ability to participate in toileting program. These will be updated quarterly and with any change of continence status.

Beginning December 23, 2013 an audit was performed to look at all resident's Bowel and bladder assessments/MDS/ Care plans (See Attachment N) to ensure continuity of care regarding resident bowel and bladder status.

C. Beginning on December 19, 2013 a Weekly audit of all New Admission paperwork including Admission orders will be conducted by the PCMs to ensure that all patients admitted with a Foley catheter have either an order to discontinue the device or a valid diagnosis and signed Physician's Order for a Foley catheter any inaccuracies were corrected

Beginning December 23, 2013 all nursing staff will be educated on the completion of the Admission Audit Tool (See Attachment T). With education completed on January 17, 2014. The nurse on the shift at the time of admission and the nurse that follows will both sign the audit tool. All items on the audit, including Presence of Foley, Justification order, and size will be completed. This will be turned in to the Charge Nurse who will sign off on it and then give it to the PCM.

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PRINTED: 12/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/18/2013
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NAME OF PROVIDER OR SUPPLIER BORDEAUX LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218
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F 315 Continued From page 8
(16 f [french] /10ml [milliliter]) change (Q [every] 30 Days & [and] PRN [as needed]) (DX [diagnosis]: SACRAL EXCORIATION...)

Review of the admission minimum data set (MDS) dated 11/23/13 documented, Resident #54 had an indwelling catheter and urinary continence was not rated.

Review of the care plan dated 11/25/13 documented, "...INCONTINENCE / INDWELLING CATHETER: She has a 16F/10ml indwelling catheter intact / patent to BSD [bedside drainage] d/t [due to] sacral excoriation..."

Observations in Resident #54's room on 12/18/13 at 11:10 AM, revealed Resident #54 with a Foley catheter in privacy bag.

During an interview at the Birmingham 2 nurses' station on 12/18/13 at 2:10 PM, Nurse #2 was asked if sacral excoriation is a proper diagnoses for a Foley. Nurse #2 stated, "No."

2. Medical record review for Resident #242 documented an admission date of 8/23/13 with diagnoses of Postoperative Respiratory Failure, Restrictive Lung Disease, Obesity, Atrial Fibrillation, Right Hemidiaphragm Dysfunction, Obstructive Sleep Apnea, Hypertension, Congestive Heart Failure, Tracheostomy, Malnutrition and Debility. Review of the interdisciplinary progress notes dated 8/28/13 at 4:30 PM documented, "...cont. [continent] of B&B [bowel and bladder]. Urinal provided 350 cc [cubic centimeters] clear yellow urine noted..." Review of section H of Resident #242's MDS dated 9/4/13 documented Resident #242 was occasionally incontinent. Review of the care plan dated

F 315

Beginning January 7, 2014 Restorative Care Nurse or Resident Assessment Manager will follow the MDS 3.0 due list for assessment date/review, which means each Resident will have a review of the continence level at least every 90-92 days in addition to any changes in between their scheduled OBRA assessments. This will also include any updates/review of care plan.

Beginning January 8, 2014 All nursing staff will be in-serviced on the Updated Bowel and Bladder Retraining Policy # 3.78 (See Attachment U) to be completed by January 17, 2014

Beginning January 8, 2014 residents will have a Bowel and Assessment (updated) B 645.0904 (See Attachment S) completed upon admission to determine their continence level and ability to participate in toileting program. These will be updated quarterly and with any change of continence status.

Learning Objectives:

- Understanding the review of Physician orders to ensure proper diagnosis is available for all Foley catheter orders
- Licensed nursing staff will understand that new Foley catheters must be added to care Plans
- Restorative program will be used to enhance resident's ability to participate in a toileting program.

1/18/14

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F 315	Continued From page 9 9/11/13 documented, "...INCONTINENCE... Resident occasionally incontinent with bladder/bowel..." with no intervention for any type of toileting program to maintain or restore continence. Review of section H of the quarterly MDS dated 11/27/13 documented Resident #242 was always incontinent of bladder and bowel. During an interview at the Birmingham 2 nurses station on 12/18/13 at 9:45 AM, Nurse #2 was asked should a bowel and bladder program have been started for Resident #242. Nurse #2 stated, "Yes."	F 315	D. The Resident Assessment Manager, Restorative Care Nurse, PCM, Nursing Supervisor, or Director of Quality/Risk Management will audit a) All residents who have a Foley catheter to ensure there is a proper diagnosis (See Attachment M) b) All residents' bowel and bladder status to ensure care plan has been provided. (See Attachment N)		
F 332 3S=D	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 "Geriatric Medication Handbook", policy review, medical record review, observation and interview, it was determined the facility failed to ensure 3 of 7 (Nurses #6, 7 and 8) medication nurses administered medications with a medication error rate of less than five percent (%). There were 3 medication errors made out of 25 opportunities for error, which resulted in a medication error rate of 12%. The findings included: 1. Review of the facility's medication administration policy documented, "...Novolog: Snack or meal within 5- [to] 10 minutes of	F 332	The threshold for compliance for the Quality Improvement process will be set at 95%. Once the threshold has been met for three (3) consecutive months, audits will be conducted as the discretion of the DON or Director of Quality/Risk Management. Audit results will be reported in monthly Quality Council Committee. F 332 A. Observation of during Med pass, nurse administered 2 units of Novolog Insulin for sliding scale orders for blood sugar greater 180. Meal was not served for 1 hour and 26 minutes. 2 separate residents both received 2 puffs of Inhalers. Of the 2 nurses giving the Inhalers, neither did not wait the required 1 minute between the puffs.		

1/18/14

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F 332 Continued From page 10
administering the insulin... "

Medical record review for Resident #306 documented an admission date of 6/28/13 with diagnoses of Vascular Dementia, Intracerebral Hemorrhage, Hypertension, Hyperlipidemia, Atrial Fibrillation, Anxiety and Diabetes Mellitus. Review of a physician's order dated 7/19/13 documented, "...ACCU CHECKS BID [twice daily] WITH NOVOLOG INSULIN SSI [sliding scale insulin] ...IF BS [BLOOD SUGAR] is > [greater than] 180 SLIDING SCALE INSULIN AS INDICATED..."

Observations in Resident #306's room on 12/18/13 at 4:09 PM, revealed Nurse #6 administered 2 units of Novolog insulin to Resident #306. Resident #306's meal tray had not been delivered as of 5:35 PM, 1 hour and 26 minutes after administration of the insulin. Resulted in medication error #1.

During an interview on the south hall, second floor Birmingham on 12/18/13 at 5:10 PM, Nurse #6 was asked about the administration of Novolog insulin in relation to meal time. Nurse #6 stated, "...[Novolog insulin] should be given 30 minutes before meals..."

During an interview on the north hall, fourth floor Birmingham on 12/18/13 at 5:30 PM, Nurse #9 was asked about the administration of Novolog insulin in relation to meal time. Nurse #9 stated, "...Normally Novolog is given with meals..."

2. Review of the "Geriatric Medication Handbook", tenth edition, page 57, documented, "...If another puff of the same or different medication is required, wait 1-2 minutes... then repeat procedure..."

F 332

B. The Administration of Medications Policy # 3.25 will be reviewed and revised by DON and Pharmacist. Beginning the week of December 27, 2013 a med pass audit will be conducted by PCM, Nursing Supervisor, Director of Quality/Risk Management, or Pharmacist to review proper procedure for giving food with Novolog that has been ordered as a scheduled insulin. In addition the audit will include proper procedure for Oral Inhalation Administration. Any inaccuracies will be corrected immediately. (See Attachment V)

C. All Licensed Nurses will be in-serviced on Medication Administration Policy #3.25 and Oral Inhalation Administration Policy #6.58 by January 17, 2014. (See Attachment W)

1/18/14

LEARNING OBJECTIVES:

- Understanding the importance of correctly administering Novolog Insulin in conjunction with food when a scheduled medication
- Understanding the importance of proper procedure when giving oral Inhalation medication

D. The PCM, Nursing Supervisor, Nurse Educator or Director of Quality/Risk Management will perform med pass audits on 20 % of all licensed nurses, monthly X 3 consecutive months with a 5% error rate. The threshold for compliance for the Quality Improvement process will be set at <5%. Once threshold is met for three (3) consecutive months, audits will be conducted at the discretion of the DON or Director of Quality/Risk Management. Audit results will be reported monthly in Quality Council Committee.

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F 332	Continued From page 11 a. Medical record review for Resident #16 documented an admission date of 8/27/13 with diagnoses of Hepatic Coma, Coronary Artery Disease, Hypertension, Osteoarthritis, Chronic Obstructive Pulmonary Disease and Psychosis. Review of a physician's order dated 9/16/13 documented, "...COMBIVENT INHALER 2 PUFFS..." Observations in Resident #16's room on 12/18/13 at 7:41 AM, Nurse #7 administered 2 puffs of a Combivent Inhaler to Resident #16. Nurse #7 waited 25 seconds between puffs. The failure to wait at least 1 minute between puffs resulted in medication error #2. b. Medical record review for Resident #177 documented an admission date of 8/8/09 with diagnoses of Diabetes Mellitus with Peripheral Vascular Disease, Coronary Artery Disease and Ischemic Heart Disease, Hypertension and Cardiovascular Disease. Review of a physician's order dated 8/8/13 documented, "...ALBUTEROL INHALER 0.09... 2 PUFFS..." Observations in Resident #177's room on 12/18/13 at 10:10 AM, revealed Nurse #8 administered two puffs of an Albuterol inhaler to Resident #177. Nurse #8 waited 20 seconds between puffs. The failure to wait at least 1 minute between puffs resulted in medication error #3.	F 332		
F 333	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333	A. Observation of during Med pass, nurse administered 2 units of Novolog Insulin for sliding scale orders for blood sugar greater 180. Meal was not served for 1 hour and 26 minutes. 2 separate residents both received 2 puffs of Inhalers. Of the 2 nurses giving the Inhalers, neither did not wait the required 1 minute between the puffs.	1/18/14

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F 333 Continued From page 12

F 333

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 ensure 1 of 7 (Nurse #6) medication nurses administered medications free of significant medication errors. Nurse #6 failed to administer insulin within the proper time frame related to meals for Resident #306.

The finding included:

Review of the facility's medication administration policy documented, "...Novolog: Snack or meal within 5- [to] 10 minutes of administering the insulin..."

Medical record review for Resident #306 documented an admission date of 6/28/13 with diagnoses of Vascular Dementia, Intracerebral Hemorrhage, Hypertension, Hyperlipidemia, Atrial Fibrillation, Anxiety and Diabetes Mellitus. Review of a physician's order dated 7/19/13 documented, "...ACCU CHECKS BID [twice daily] WITH NOVOLOG INSULIN SSI [sliding scale insulin] ...IF BS [BLOOD SUGAR] is > [greater than] 180 SLIDING SCALE INSULIN AS INDICATED..."

Observations in Resident #306's room on 12/18/13 at 4:09 PM, revealed Nurse #6 administered 2 units of Novolog insulin to Resident #306. Resident #306's meal tray had not been delivered as of 5:35 PM, 1 hour and 26 minutes after administration of the insulin. this resulted in a significant medication error.

During an interview on the south hall, second

B. The Administration of Medications Policy # 3.25 will be reviewed and revised by DON and Pharmacist. Beginning the week of December 27, 2013 a med pass audit will be conducted by PCM, Nursing Supervisor, Director of Quality/Risk Management or Pharmacist to review proper procedure for giving food with Novolg that has been ordered as a scheduled Insulin. In addition the audit will include proper procedure for Oral Inhalation Administration. Any inaccuracies will be corrected immediately. (See Attachment V)

C. All Licensed Nurses will be in-serviced on Medication Administration Policy #3.25 and Oral Inhalation Administration Policy #6.58 by January 17, 2014. (See Attachment W)

LEARNING OBJECTIVES:

- Understanding the importance of correctly administering Novolog Insulin in conjunction with food when a scheduled medication
- Understanding the importance of proper procedure when giving oral Inhalation medication
- D. The PCM, Nursing Supervisor, Nurse Educator or Director of Quality/Risk Management will perform med pass audits on 20 % of all licensed nurses, monthly X 3 consecutive months with a 5% error rate. The threshold for compliance for the Quality Improvement process will be set at <5%. Once threshold is met for three (3) consecutive months, audits will be conducted at the discretion of the DON or Director of Quality/Risk Management. Audit results will be reported monthly in Quality Council Committee.

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F 333 Continued From page 13
floor Birmingham on 12/18/13 at 5:10 PM, Nurse #6 was asked about the administration of Novolog insulin in relation to meal time. Nurse #6 stated, "...[Novolog insulin] should be given 30 minutes before meals..."

F 333

During an interview on the north hall, fourth floor Birmingham on 12/18/13 at 5:30 PM, Nurse #9 was asked about the administration of Novolog insulin in relation to meal time. Nurse #9 stated, "...Normally Novolog is given with meals..."

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

F 371

F371

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

A. December 17, 2013 and December 18, 2013 the Director of Food and Nutrition and the Dietary Manager inspected all department food storage areas to assure all foods were Covered, Dated and Labeled (CDL) and within expiration date.

1/18/14

This REQUIREMENT is not met as evidenced by:
Based on policy review, observation and interview, it was determined the facility failed to ensure food was not stored past the expiration date and failed to ensure food was dated when opened on 1 of 3 (12/16/2013) days of the survey.

December 23, 2013 all dietary supervisors were instructed on F-tag 371, including information on Cover, Date and Label (CDL) and First In First Out (FIFO). (See Attachment X)

The findings included:

Review of the facility's food storage policy documented, "...It is our policy to prepare and store food that is stored in accordance with

December 26, 2013 dairy company contacted by Dietary Manager to establish an understanding on rotation of all dairy products and establish an area in the dairy cooler "Do Not Use Expired" to identify products that are to be returned for credit.

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F 371	<p>Continued From page 14</p> <p>federal, state, and local sanitary codes... Procedure... 2. Refrigerator... d. Raw meats, poultry, and fish will be wrapped labeled, and dated... f. Milk will be rotated with each delivery... Milk with the earliest expiration date will be used first... 4... a. All leftovers will be properly sealed... labeled, and dated..."</p> <p>Observations in the kitchen on 12/16/13 at 11:15 AM revealed the following: a. Dairy cooler had two eight ounce cartons of fat free milk and a gallon of buttermilk stored past the expiration date of 12/13/13. b. Dairy cooler had a quart of heavy whipping cream with a manufacturer's use-by date of 12/15/13 with a hand-written label stating, "Use by 11/23/13." c. Meat cooler had an opened container of chicken bacon with no date when it was opened. d. Produce cooler had an opened, undated container of pimento and cheese spread that was not dated when it was opened.</p> <p>During an interview in the kitchen on 12/16/13 at 11:15 AM, the Registered Dietician (RD) was asked about the opened and undated container of chicken bacon. The RD stated, "I'll throw that away."</p> <p>During an interview in the kitchen on 12/17/13 at 9:45 AM, the Dietary Manager (DM) was asked about the expired milk products. The DM stated, "We use a crate specifically for outdated milk in the dairy cooler, so it can be returned to the vendor for credit." These items were not in the expired crate. The DM was asked if these items got missed. The DM stated, "Yes."</p>	F 371	<p>January 2, 2014 additions made to DLT rounds guide to increase the number of inspections of CDL.</p> <p>January 8, 2014 dairy company sent letter to confirm expectations on delivery and rotation of product. (See Attachment Y)</p> <p>B. The dietary policies on Food Storage and on Receiving Food were updated to reflect FIFO and CDL. (See Attachment Z)</p> <p>C. By January 17, 2014 all dietary personnel will be required to complete in-service training on the updated Food Storage and Receiving Food policies with return demonstration on rotating stock and CDL. (See Attachment Z)</p> <p>Learning objectives:</p> <ul style="list-style-type: none"> • Understand proper cover, date and label procedures for food storage • Understand proper rotation of stock to assure food safety, FIFO 	1/18/14
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		

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F 371	<p>Continued From page 14</p> <p>federal, state, and local sanitary codes... Procedure... 2. Refrigerator... d. Raw meats, poultry, and fish will be wrapped labeled, and dated... f. Milk will be rotated with each delivery... Milk with the earliest expiration date will be used first... 4... a. All leftovers will be properly sealed... labeled, and dated..."</p> <p>Observations in the kitchen on 12/16/13 at 11:15 AM revealed the following:</p> <p>a. Dairy cooler had two eight ounce cartons of fat free milk and a gallon of buttermilk stored past the expiration date of 12/13/13.</p> <p>b. Dairy cooler had a quart of heavy whipping cream with a manufacturer's use-by date of 12/15/13 with a hand-written label stating, "Use by 11/23/13."</p> <p>c. Meat cooler had an opened container of chicken bacon with no date when it was opened.</p> <p>d. Produce cooler had an opened, undated container of pimento and cheese spread that was not dated when it was opened.</p> <p>During an interview in the kitchen on 12/16/13 at 11:15 AM, the Registered Dietician (RD) was asked about the opened and undated container of chicken bacon. The RD stated, "I'll throw that away."</p> <p>During an interview in the kitchen on 12/17/13 at 9:45 AM, the Dietary Manager (DM) was asked about the expired milk products. The DM stated, "We use a crate specifically for outdated milk in the dairy cooler, so it can be returned to the vendor for credit." These items were not in the expired crate. The DM was asked if these items got missed. The DM stated, "Yes."</p>	F 371	<p>D. The Director of Food and Nutrition, Dietary Manager, Dietitians, and Dietary Supervisors will audit all food storage areas for proper rotation of stock and CDL four times a week for at least three (3) months to ensure policies concerning FIFO and CDL are properly implemented.</p> <p>Audit results will be reported monthly in Quality Council Committee.</p> <p>The threshold for compliance for the Quality Improvement process will be set at 95%. Once threshold has been met for three (3) consecutive months, audits will be conducted at the discretion of the Director of Food and Nutrition, the Dietary Manager or the Director of Quality/Risk Management.</p>	1/18/14
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		

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F 431 Continued From page 15
SS=D 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.

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.

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.

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.

This REQUIREMENT is not met as evidenced by:
Based on policy review, observation and

F 431 F-Tag #431

A. It was determined the facility failed to ensure medications were stored properly as evidenced by a Heparin syringe laying on top of a medication cart, internal medications stored with external medications and disinfectant wipes and medications not dated when opened in 3 of 26 (B2 South hall medication cart, B3 North hall medication cart and B. 2 North medication cart) medication storage areas.

B. To identify other residents potentially affected all medication carts within the facility were immediately checked beginning December 19, 2013. Any improper storage of medication, biologicals in med cart were immediately corrected.

C. Policy #6.69 "Medication Storage" will be reviewed and updated by DON and Pharmacy Consultant by December 19, 2013. All licensed staff will be in-serviced on the updated policy #6.69 Medication Storage beginning December 23, 2013. (See Attachment AA) Pharmacy Consultant will do weekly audits of the medication carts for improperly stored medications and complete a "Medication Cart Expired Med Review Tool" and errors will be corrected (See Attachment BB)

Learning Objectives include:

- Understanding the importance of checking medication for proper storage.
- Ensuring that review of medication carts for improperly stored meds are routinely a part of the medication pass.

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F 431 Continued From page 16

interview, it was determined the facility failed to ensure medications were stored properly as evidenced by a Heparin syringe laying on top of a medication cart, internal medications stored with external medications and disinfectant wipes and medications not dated when opened in 3 of 26 (Birmingham 2 south hall medication cart, Birmingham 3 north hall medication cart and Birmingham 2 north medication cart) medication storage areas.

The findings included:

1. Review on the facility's medication storage policy documented, "...C. Orally administered medications are kept separate from externally used medications, such as suppositories, liquids, and lotions... F. Except for those requiring refrigeration, medications intended for internal use are stored in medication cart... H. Potentially harmful substances (such as... disinfectants)... stored in a locked area separately from medications..."
2. Observations on Birmingham 2 south hall on 12/17/13 at 11:39 AM, revealed a 1 milliliter syringe of Heparin laying on top of the Birmingham 2 medication cart unattended and out of the nurses' view.

During an interview on Birmingham 2 south hall on 12/17/13 at 11:39 AM, Nurse #1 was asked what was in the syringe and what should have been done concerning the syringe of Heparin laying on the medication cart. Nurse #1 stated, "...Heparin... should have drawn it up when ready to take the rest of the medicines in [to the resident]..."

F 431

D. The Pharmacy Consultant, PCM or Charge Nurse will audit periodically during the month each medication cart to ensure there are not any improperly stored medications present for least 3 months. The threshold for compliance for the Quality Improvement process will be set at 95%. Once threshold has been met for three (3) consecutive months, audits will be conducted at the discretion of the DON or Director of Quality/Risk Management. Audit results will be reported monthly in Quality Council Committee.

1/18/14

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/18/2013
NAME OF PROVIDER OR SUPPLIER BORDEAUX LONG TERM CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218		
(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 431	<p>Continued From page 17</p> <p>During an interview in the Birmingham 2 nurse manager's office on 12/17/13 at 12:08 PM, Nurse #2 was asked what should the nurse have done with the syringe left laying on the medication cart unattended. Nurse #2 stated, "...Would have expected [Nurse #1] to put it back in the cart and lock it up..."</p> <p>During an interview in the Director of Nursing's (DON) office on 12/18/13 at 5:20 PM, the DON was asked where would she expect Heparin injection to be stored. The DON stated, "...in the med [medication] cart..."</p> <p>3. Observations on Birmingham 3 north hall on 12/17/13 at 2:20 PM, revealed the Birmingham 3 north hall medication cart had packaged Ibuprofen tablets stored in a box with antibiotic ointment packets, an unlabeled suppository stored with Acetaminophen tablets, 4 containers of Sani-Hands wipes stored in a drawer with liquid medications.</p> <p>During an interview on the Birmingham 3 north hall on 12/17/13 at 2:35 PM, Nurse #4 stated in regards to the Sani-Hands wipes "...they're not open..."</p> <p>During an interview in the Director of Nursing's (DON) office on 12/18/13 at 5:20 PM, the DON was asked where would she expect Heparin injection to be stored. The DON stated, "...in the med [medication] cart..."</p> <p>4. Observations on the Birmingham 2 north hall on 12/17/13 at 2:45 PM, revealed the Birmingham 3 north hall medication cart contained Pyrazinamide and Vasolex ointments that were not dated when opened.</p>	F 431		

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STATEMENT OF DEFICIENCIES & PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/18/2013
NAME OF PROVIDER OR SUPPLIER BORDEAUX LONG TERM CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218		
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F 431	Continued From page 18 During an interview on Birmingham 2 north hall on 12/17/13 at 2:55 PM, Nurse #5 was asked if the medication should be dated when opened. Nurse #5 stated, "...I would assume so, everything that has been opened would need a date..." During an interview in the DON's office on 12/18/13 at 5:20 PM, the DON was asked if multiple dose medications should be dated when opened. The DON stated, "...would expect it to be dated..."	F 431		
F 441 SS=D	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 - (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	F 441	F441 A. Observation of during Med pass, nurse administered eye drops in one residents' eyes. She did not wash hands or change gloves before administering eye drops into the resident's. B. Beginning the week of December 27, 2013 a med pass audit will be conducted by PCM, Nursing Supervisor, Quality Manager, or Pharmacist to review proper procedure for eye drops instillation and handwashing/glove technique. Any inaccuracies will be corrected immediately. C. All Licensed Nurses will be in-serviced on "Eye Drops Administration Procedure" Policy #6.52 by January 17, 2014. (See Attachment CC)	1/18/14

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NAME OF PROVIDER OR SUPPLIER BORDEAUX LONG TERM CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218		
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F 441	<p>Continued From page 19</p> <p>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 and observation, it was determined the facility failed to ensure 1 of 7 (Nurse #10) medication nurses failed to change gloves between administering eye drops into Resident #247's eyes to prevent the potential spread of infection or cross contamination.</p> <p>The findings included:</p> <p>Review of the facility's "Med Pass Technique" documented, "...change gloves in between each eye drop administration..."</p> <p>Observations in Resident #247's room on 12/17/13 at 2:32 PM, Nurse #10 administered eye drops in one of Resident #247's eyes. Nurse #10 did not wash hands or change gloves before administering eye drops into Resident #247's other eye.</p>	F 441	<p>LEARNING OBJECTIVES:</p> <ul style="list-style-type: none"> Understanding the importance of correctly washing hands when instilling eye drops Understanding all steps involved to accurately instill eye drops into both eyes for a resident <p>D. The PCM, Charge Nurse or Director of Quality/Risk Management will perform med pass audits which includes Eye Drops Administration (See Attachment DD) on 20 % of all licensed nurses for at least 3 months. The threshold for compliance for the Quality Improvement process will be set at < 5%. Once threshold is met for three (3) consecutive months, audits will be conducted at the discretion of the DON or Director of Quality/Risk Management. Audit results will be reported monthly in Quality Council Committee.</p>	1/18/14

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JAN 10 2014