

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

PRINTED: 01/10/2012
FORM APPROVED
OMB NO. 0938-0391

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445133	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>JAN 19 2012</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/28/2011
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NAME OF PROVIDER OR SUPPLIER ALLEN MORGAN HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 177 NORTH HIGHLAND MEMPHIS, TN 38111
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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 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to ensure the Minimum Data Set (MDS) was accurately coded for falls for 1 of 5 (Resident #1) sampled residents with falls.</p>	F278	<p>This plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by the state and federal law.</p> <p>The Minimum Data Set (MDS) for resident #1 has been corrected to accurately reflect falls.</p> <p>All residents having a fall have the potential to be affected by the deficient practice.</p> <p>All residents with falls for the last 90 days will be audited to ensure that the MDS is accurately coded for falls. MDS coordinators will be in-serviced to include all falls on the MDS assessment.</p> <p>Residents with falls will be reviewed in morning meeting. MDS coordinator will update MDS assessment promptly upon exiting morning meeting to ensure MDS is accurate.</p> <p>DON and/or designee will review MDS data weekly at Falls Meeting to ensure accuracy of coding.</p> <p>Findings will be reported to QA & A meeting monthly x 2, then PRN thereafter.</p>	01/28/12
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Plomer Hunter</i>	TITLE ADMIN	(X6) DATE 1/10/12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 278

Continued From page 1

The findings included:

Medical record review for Resident #1 documented an admission date of 11/9/11 with diagnoses of Hip Fracture, Difficulty Walking, Muscle Weakness, Atrial Fibrillation and Gout. Review of Resident #1's nurse's notes documented a fall on 11/18/11. Review of a physician's order dated 11/21/11 documented an order for a left hip X-ray related to a fall. Review of the 14-day and 30-day MDS scheduled assessment documented, "...J1800. Any Falls Since Admission or Prior Assessment... 0. No..."

During an interview in the MDS office on 12/28/11 at 2:10 PM, Nurse 33 was asked why the fall on 11/18/11 was not reflected on the MDS. Nurse #3 stated, "...should have been on the 11/22/11 MDS..."

F 278

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 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

F 280

The care plan for resident #1 was revised to accurately reflect a supra-pubic catheter and to delete secure catheter bag to leg to avoid tension on urinary meatus and to delete to change catheter bag every 30 days.

All residents with supra-pubic catheters have the potential to be affected by the deficient practice.

All residents with supra-pubic catheters will be reviewed to ensure that the care plan interventions are appropriate.

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F 280	<p>Continued From page 2</p> <p>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 revise the comprehensive care plan for a suprapubic catheter for 1 of 8 (Resident #1) sampled residents.</p> <p>The findings included:</p> <p>Review of the facility's "Care Plans - Comprehensive" policy documented, "...5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes... 6. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident..."</p> <p>Medical record review for Resident #1 documented an admission date of 11/9/11 with diagnoses of Hip Fracture, Difficulty Walking, Muscle Weakness, Atrial Fibrillation and Gout. Review of a physician's order dated 12/16/11 documented, "...Suprapubic catheter, tubing & [and] bag to be changed Q [every] 2 weeks..." Review of the care plan dated 11/16/11 documented, "...2: Secure catheter to leg to avoid tension on urinary meatus... 3: Change catheter every 30 days and PRN [as needed] to assure patency..."</p>	F 280	<p>Residents with supra-pubic catheters will have interventions individually care planned according to physician's orders. MDS coordinators will be in-serviced on making care plans resident specific.</p> <p>The MDS coordinator will review each care plan for accuracy and will report to the DON and/or designee weekly on those residents with supra-pubic catheters.</p> <p>DON and/or designee will review weekly x 4, then monthly x 2, then randomly to ensure accuracy.</p> <p>Findings will be reported to the QA & A meeting monthly x 2, then PRN thereafter.</p>	01/28/12
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F 280	<p>Continued From page 3</p> <p>Observations in Resident #1's room on 12/27/11 at 6:30 PM, 12/28/11 at 7:30 AM and 10:30 AM, revealed Resident #1 with a suprapubic catheter attached to a leg bag.</p> <p>During an interview in the Minimum Data Set office on 12/28/11 at 2:10 PM, Nurse #4 was asked if the interventions for changing the catheter bag and the intervention for the leg bag in relation to the urinary meatus were accurate based on the resident having a suprapubic catheter. Nurse #4 stated, "...No..."</p> <p>F 323 SS=D 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</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 ensure that a resident that was at risk for falls had interventions implemented after a fall for 1 of 3 (Resident #1) sampled residents.</p> <p>The findings included</p> <p>Medical record review for Resident #1 documented an admission date of 11/9/11 with diagnoses of Hip Fracture. Difficulty Walking.</p>	F 280	<p>F 323 Bed alarm was placed on bed for resident #1.</p> <p>All residents care planned for bed alarms have the potential to be affected by the deficient practice.</p> <p>All residents with care plans for bed alarms will be audited to ensure that bed alarms are in place.</p> <p>A bed alarm monitoring form will be completed on each resident when a bed alarm is put in place. The nurse and C.N.A. will monitor each shift to ensure that the alarm is in place and will document on the alarm monitoring form to verify that alarm is in place. Staff will be in-serviced on alarm monitoring form.</p>	01/28/12

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F 323 Continued From page 4
Muscle Weakness, Atrial Fibrillation and Gout. Review of Resident #1's nurse's notes documented a fall on 11/18/11. Review of a physician's order dated 11/21/11 documented an order for a left hip X-ray related to a fall. Review of the care plan dated 11/16/11 documented, "...11/18/11 Bed Alarm @ [at] all times when in bed..."

Observations in Resident #1's room on 12/28/11 at 7:30 AM, revealed Resident #1 lying in bed, with no bed alarm present as care planned.

During an interview in Resident #1's room on 12/28/11 at 12:27 PM, Certified Nursing Assistant (CNA) #1 was asked if Resident #1 had a bed alarm on her bed. CNA #1 stated, "...No..." CNA #1 confirmed there was no bed alarm on Resident #1's bed nor was there a bed alarm in the room.

During an interview in the Unit 2 Conference room on 12/28/11 at 2:50 PM, Nurse #1 was asked about the bed alarm for Resident #1. Nurse #1 stated "...I don't know when it [bed alarm] was taken off..."

F 323 The DON and/or designee will audit the alarm monitoring forms weekly x4, then monthly to ensure compliance.

Findings will be reported to the QA & A meeting monthly x2, then PRN thereafter.

F 333 SS=D 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS

The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:
Based on review of the "2011 Mosby's NURSING DRUG REFERENCE", review of the "MED-PASS COMMON INSULINS: Pharmacokinetics.

F 333 Resident #7 was monitored for signs and symptoms of hypoglycemia with no adverse effects. MD was notified.

All residents receiving regular insulin have the potential to be affected by the deficient practice.

Nurses will be in-serviced on administration of regular insulin 30 minutes prior to food consumption.

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F 333	<p>Continued From page 5</p> <p>Compatibility, and Properties" provided by the American Society of Consultant Pharmacist, medical record review, observation and interview, it was determined 1 of 3 (Nurses #1) nurses administering medications failed to ensure a resident was free of a significant medication error.</p> <p>The findings included:</p> <p>Review of the "2011 Mosby's NURSING DRUG REFERENCE, 24th Edition" documented, "...Short Acting insulin, regular... Novolin R [regular]... PHARMACOKINETICS... Short acting Insulin regular: Onset 30 min [minutes], peak 2.5- [to] 5 hr [hour], duration up to 6 hr..."</p> <p>Review of the "MED-PASS COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties" provided by the American Society of Consultant Pharmacist for typical dosing administration of insulin related to meals documented, Novolin R... TYPICAL DOSING / COMMENTS... 30 minutes before meals..."</p> <p>Medical record review for Resident #7 documented an admission date of 12/23/11 with diagnoses of Hypertension, Diabetes Mellitus, Arthritis and Depression. Review of the physician's orders dated 12/27/11 documented, "...Accu checks AC [before meals] & [and] HS [hour of sleep] c [with] sliding scale insulin c Novolin R... 301- [to] 350 [administer] 11 units..."</p> <p>Observations in Resident #7's room on 12/27/11 at 11:57 AM, Nurse #1 administered 11 units of Novolin R insulin to Resident #7. Resident #7's lunch tray was delivered to her at 12:33 PM and</p>	F 333	<p>Facility protocol will be to give regular insulin 30 minutes or less prior to food consumption. Nurses will maintain a snack on medication cart and will ensure that resident receives food within 30 minutes of administration of regular insulin.</p> <p>DON and/or designee will observe medication pass weekly x4, then monthly x2, then randomly to ensure compliance.</p> <p>Findings will be reported to the QA & A meeting monthly x2, then PRN thereafter.</p>	

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F 333	Continued From page 6 Resident #7 took the first bite of food 12:35 PM. The administration of the insulin 38 minutes before Resident #7 took her first bite of food, resulted in a significant medication error.	F 333		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to offer bedtime (HS) snacks to 12 of 15 residents on the Unit 2 hall.	F 368	HS snacks were offered to those residents that could receive a snack. All residents have the potential to be affected by the deficient practice. Staff will be in-serviced on the delivery of HS snacks. C.N.A.s will deliver HS snacks and will document on the resident roster of the resident accepted or refused the snack. The nurse will review the roster and will randomly audit residents to ensure that HS snacks were offered. The nurse will then sign the bottom of the roster. The DON and/or designee will review the roster daily to ensure compliance. Random audits of residents will be completed by the DON and/or designee to ensure HS snacks are being offered. Findings will be reported to the QA & A meeting monthly x2, then PRN thereafter.	01/28/12

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F 368	<p>Continued From page 7</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's "Snacks (Between Meal and Bedtime), Serving for Level I" policy documented, "...The purpose is to provide the resident with adequate nutrition..." 2. During the group interview in the Parlor on 12/27/11 at 3:00 PM, the six alert and oriented residents attending the group interview were asked about bedtime snacks. The six (6) residents attending the group interview stated they were not offered bedtime snacks. 3. Observations on Unit 2 on 12/27/11 from 8:45 PM to 8:58 PM revealed, Certified Nursing Assistant (CNA #2) failed to offer HS snacks when passing out water to rooms #131, 133, 135, 136, 137, 138, 139, 140, and 141. <p>During an interview on Unit 2 hall on 12/27/11 at 9:15 PM, CNA #2 was asked if bedtime snacks were offered. CNA #2 stated, "...No..."</p> <ol style="list-style-type: none"> 4. During an interview in the Social Worker's office on 12/28/11 at 3:45 PM, the Director of Nursing (DON) was asked who is responsible for passing out HS snacks. The DON stated, "...Nurse and CNA... snacks consist of sandwiches, Ensure and peanut butter and crackers..." The DON was asked when HS snacks were offered. The DON stated, "...anytime... 7:30 PM to 9:00 PM... depends on patient..." 	F 368		
F 371 SS=E	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 8 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 This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure proper kitchen sanitation practices were maintained as evidenced by out-of-date food stored in a cooler; hot food was maintained at 135 degrees Fahrenheit (F) or above and staff failed to clean a thermometer before taking tray line temperatures. The findings included: 1. Observations in the kitchen walk-in cooler on 12/27/11 at 9:45 AM, revealed the following food stored past the expiration date: a. Two - 3 pound (lb) tubs of cottage cheese with an expiration date of 12/10/11. b. One - 3 lb tub of cottage cheese with an expiration date of 12/17/11. c. One - 3 lb tub of cottage cheese with an expiration date of 12/21/11. d. One - 3 lb tub of cottage cheese with no expiration date legible e. One - 1/2 gallon jug of buttermilk with an expiration date of 12/15/11. f. Two - 1/2 gallon jugs of buttermilk with an	F 371	The expired foods were disposed of immediately upon notification of non-compliance. The food was reheated to appropriate temperature before the food cart was delivered and food was served. The thermometer was recalibrated and sanitized immediately upon notification of contamination of thermometer. Dietary staff will be in-serviced on stock rotation using the first-in/ first-out method. Cooks and food-prep workers will be in-serviced on the proper procedure for thermometer calibration and usage. Cooks and food-prep workers will be in-serviced on how to accurately take food temperatures according to the facility policy. The stock will be arranged according to delivery dates. Each cook and/or food-prep staff will have to do a return demonstration of thermometer calibration weekly to the dietary manager and/or designee. The kitchen manager will check food temperatures before each meal and each food cart to ensure that the proper food temperature is being maintained throughout the meal. The kitchen manager and/or designee will be responsible for checking in all stock and signing all invoices upon delivery verifying that all stock has appropriate dates and is stored in the first-in/first-out method. The CDM will do random weekly audits and will report findings to the QA & A meeting monthly x 2, then PRN thereafter.	01/28/12	

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F 371	<p>Continued From page 9 expiration date of 12/25/11.</p> <p>During an interview in the kitchen on 12/27/11 at 9:55 AM, Dietary Manager (DM) #1 was asked how often the dietary staff check the expiration dates of the food in the cooler. DM #1 stated, "...we check it daily..."</p> <p>2. Review of the facility's "TAKING FOOD TRAY TEMPERATURES" policy documented, "...ALL HOT FOOD ITEMS MUST BE COOKED TO APPROPRIATE INTERNAL TEMPERATURES, HELD AND SERVED AT A TEMPERATURE OF AT LEAST 135 DEGREES F [Fahrenheit]..."</p> <p>Observations in the kitchen on 12/28/11 at 12:12 PM, revealed the following hot food tray line temperatures:</p> <ul style="list-style-type: none"> a. Mashed potatoes - 131 degrees F. b. Egg plant - 130 degrees F. c. Marinara sauce - 129 degrees F. d. Chicken - 130 degrees F. e. Country fried steak - 122 degrees F. <p>During an interview in the kitchen on 12/28/11 at 12:50 PM, DM #2 confirmed the tray line temperatures for hot foods are to be at least 135 degrees F.</p> <p>3. Review of the facility's "TAKING FOOD TRAY TEMPERATURES" policy documented, "...TO TAKE TEMPERATURES, A CLEAN SANITIZED AND AIR-DRIED THERMOMETER IS NEEDED..."</p> <p>Observations in the kitchen on 12/28/11 at 12:33 PM, dietary worker #1 picked up a thermometer from the counter with the tip touching the counter</p>	F 371	<p>The CDM will do weekly audits of the cooks and/or food-prep staff to ensure compliance. Findings will be reported to QA & A meeting monthly x2, then PRN thereafter.</p> <p>The CDM will do weekly audits of the food temperatures and the food carts to ensure compliance. Findings will be reported to the QA & A meeting X 2, then PRN thereafter.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/28/2011	
NAME OF PROVIDER OR SUPPLIER ALLEN MORGAN HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 177 NORTH HIGHLAND MEMPHIS, TN 38111		
(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 371	Continued From page 10 and placed the thermometer in the pureed chicken without cleaning it while taking tray line temperatures. Observations in the kitchen on 12/28/11 at 12:38 PM, dietary worker #1 picked up a thermometer from the counter with the tip touching the counter and placed the thermometer in the egg plant without cleaning it while taking tray line temperatures. During an interview in the kitchen on 12/28/11 at 12:50 PM, DM #2 was asked about the facility's policy for taking tray line temperatures. DM #2 stated, "...clean the thermometer before putting it into the food..."	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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	F 431	The medication cart was locked immediately upon notification of non-compliance. Each nurse has the potential to be affected by the deficient practice of not securing a medication cart while administering medications. Licensed nursing staff will be in-serviced on drug storage and securing the medication cart. DON and/or designee will do random audits daily x 2 weeks, then weekly x 2 months, then PRN thereafter to ensure compliance. Findings will be reported to the QA & A meeting monthly x2, then PRN thereafter.	01/28/12

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F 431	<p>Continued From page 11</p> <p>controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined 1 of 3 (Nurse #1) nurses administering medications failed to ensure the medication cart was locked when unattended and out of view.</p> <p>The findings included:</p> <p>Review of the facility's "Security of Medication Cart" policy documented, "...3. When it is not possible to park the medication cart in the doorway, the cart should be parked in the hallway against the wall with doors and drawers facing the wall. The cart must be locked before the nurse enters the resident's room. 4. Medication carts must be locked at all times when out of the nurse's view..."</p> <p>Observations on Unit 2 hall on 12/27/11 at 11:50 AM, Nurse #1 entered room #146 and left the medication cart unlocked.</p>	F 431			

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F 431	Continued From page 12 Observations on Unit 2 hall on 12/28/11 at 9:30 AM, Nurse #1 entered room #142 and left the medication cart unlocked. During an interview on Unit 2 hall on 12/28/11 at 12:20 PM, Nurse #1 confirmed that the medication cart was left unlocked on 12/27/11 at 11:50 AM and on 12/28/11 at 9:30 AM.	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 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	F 441	Glucometer was cleaned with bleach wipe immediately upon notification of the deficient practice. Eye gtt. bottle was cleaned with alcohol wipe and bag was replaced immediately upon being notified of the deficient practice. All licensed nursing staff have the potential to be affected by the deficient practice. All glucometers and eye gtt. have the potential to be affected by the deficient practice. Licensed nursing staff will be In-serviced on appropriate hand washing protocol and on use, cleaning and storage of glucometer and eye gtt. Licensed nursing staff will be instructed on using barriers in residents rooms when using multi-use equipment. Licensed nursing staff will complete skills check off for hand washing.	01/28/12	

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F 441	<p>Continued From page 13</p> <p>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, observation and interview, it was determined 2 of 3 (Nurse #1 and 2) nurses failed to maintain infection control practices to prevent the possibility of cross contamination by not cleaning resident equipment and improper handwashing during the medication pass.</p> <p>The findings included:</p> <p>1. Review of the facility's "Handwashing/Hand Hygiene" policy documented, "...General Guidelines... 4. If hands are not visibly soiled, use an alcohol-based hand rub for all the following situations... a. Before direct contact with residents... d. Before preparing or handling medications... Washing hands... 3. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel..."</p> <p>Observations during the medication pass in room #146 on 12/27/11 at 11:45 AM and 11:56 AM. Nurse #1 washed her hands and turned the water off without using a paper towel.</p>	F 441	<p>DON and/or designee will complete medication pass observations weekly x4, then monthly x2, then randomly to ensure appropriate use, cleaning and storage of glucometers and eye gtt. DON and/or designee will have licensed nursing staff to complete skills check off quarterly for hand washing technique.</p> <p>Findings will be reported to the QA & A meeting monthly x2, then PRN thereafter.</p>		

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F 441	<p>Continued From page 14</p> <p>Observations during the medication pass in room #133 on 12/28/11 at 9:05 AM, Nurse #1 washed her hands and turned the water off without using a paper towel.</p> <p>During an interview on the Unit 2 hall on 12/28/11 at 12:20 PM, Nurse #1 was asked about turning the water off with her bare hand. Nurse #1 stated, "...I turned it [faucet] off with my elbow..."</p> <p>3. Review of the facility's "Decontaminating and Labeling Equipment" policy documented, "...1. Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturer's instructions..."</p> <p>Review of the facility's "Blood Sampling - Capillary (Finger Sticks)" documented, "...8. Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use..."</p> <p>Review of the facility's "ASCP's [American Society of Consultant Pharmacist] Summary of Glucometer Cleaning Guidelines - February 2010" guidelines documented, "...Diabetes-care procedures and techniques... If glucometers are shared, the device must be cleaned and disinfected between each patient use... Because of possible inadvertent contamination, unused supplies and medications taken to a patient's bedside during fingerstick monitoring or insulin administration should not be used for another patient..."</p> <p>Observations during the medication pass in room #140 on 12/27/11 at 5:16 PM. Nurse #2 placed</p>	F 441		
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F 441	<p>Continued From page 15</p> <p>the glucometer and the glucometer strip container on the resident's bed without a barrier, performed a fingerstick blood sugar (FSBS), then returned to the medication cart and placed the glucometer and glucometer strip container into the drawer. Nurse #2 did not clean the glucometer or glucometer strip container before or after performing the FSBS.</p> <p>Observations during the medication pass in room #146 on 12/27/11 at 5:28 PM, Nurse #2 placed the glucometer and the glucometer strip container on the overbed table without a barrier, performed a FSBS, returned to the medication cart and placed the glucometer and the glucomenter strip container into the drawer. Nurse #2 did not clean the glucometer or the glucometer strip container before or after performing the FSBS.</p> <p>During an interview on the Unit 2 hall on 12/27/11 at 6:40 PM, Nurse #2 was asked if she had used a barrier for the glucometer and the glucometer strip container. Nurse #2 stated, "...No..." Nurse #2 was asked if she had cleaned the glucometer after performing FSBS on the residents in Room #140 and 146. Nurse #2 stated, "...No I didn't..."</p> <p>During an interview in the Conference room on Unit 2 on 12/27/11 at 8:00 PM, the Director of Nursing (DON) was asked for the manufacturer's recommendations for cleaning the glucometer. The DON stated, "...we go by this [referred to the ASCP's Summary of Glucometer Cleaning Guidelines - February 2010]..."</p> <p>4. Observations during the medication pass in room 133 on 12/28/11 at 9:05 AM. Nurse #1 placed a plastic bag which contained a bottle of</p>	F 441			

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F 441	<p>Continued From page 16</p> <p>eye drops on the overbed table without a barrier. Nurse #1 administered one drop to the right eye, placed the eye drop bottle on the overbed table without a barrier. Nurse #1 then completed administration of the eye drops, placed the bottle back in the plastic bag and returned to the medication cart and placed the bag in the drawer.</p> <p>During an interview on the Unit 2 hall on 12/28/11 at 12:20 PM, Nurse #1 confirmed she did place the eye drops and bag on the overbed table without a barrier and then placed them in the medication cart drawer.</p>	F 441		
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