

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

45th 4, 0/11

PRINTED: 02/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445159	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 421 OCALA DRIVE NASHVILLE, TN 37211
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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 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>	F 441	<p>Opened O2 Tubing, O2 Mask, Suction Catheter and 4 Dressing Kits immediately removed from the supply room.</p> <p>Supply room on 1st and 2nd Floor and Central Supply Room immediately inspected for other supplies with opened packaging or expired and none were found.</p> <p>Staff inserviced on Policy and Procedure for supply storage beginning 2-23-11.</p> <p>Central Supply Clerk will conduct weekly inspections for four weeks and then monthly inspections per policy. Findings will be reported to the QI Committee on a monthly basis.</p>	3-4-11
---------------	--	-------	---	--------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 3-4-2011
--	-------------------------------	------------------------------

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.

MAR 08 2011

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

PRINTED: 02/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445159	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHANY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 421 OCALA DRIVE NASHVILLE, TN 37211
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 441	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain sterile supplies in a manner to prevent contamination and the spread of infection in one of two medication rooms.</p> <p>The findings included:</p> <p>Observation of the medication room on the second floor on February 23, 2011, at 2:45 p.m., revealed unpackaged oxygen tubing lying in the bin with other packaged oxygen tubing and available for resident use.</p> <p>Further observation revealed an opened package containing oxygen tubing and face mask in the bin with other packaged oxygen tubing and face masks and available for resident use.</p> <p>Continued observation revealed a Suction Catheter kit with the package opened stacked on the shelf with other packaged suction catheter kits available for resident use.</p> <p>Further observation revealed four PICC (peripherally inserted central catheter) dressing kits had expired. Three kits had an expiration date of 8/10 and one had an expiration date of 4/10.</p> <p>During interview on February 23, 2011, at 3:20 p.m., in the second floor medication room, the Clinical Coordinator confirmed the findings.</p>	F 441		
-------	--	-------	--	--

MAR 08 2011