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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345394 | A. BUILDING _____ B. WING _____ | 04/13/2011 |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BROOK STONE LIVING CENTER | 8990 HWY 17 SOUTH , PO BOX 429 POLLOCKSVILLE, NC 28573 |

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| F 176 SS=D | 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE<br><br>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and interviews the facility failed to assess a resident for self administration of medications for 1 of 1 sampled resident self administering medications (Resident #15). Findings include:<br><br>Resident #15 was admitted to the facility on 11/20/10 with diagnoses including Atrial Fibrillation, Dry Eyes, Hypertension, Cerebral Arterial Occlusion with Right Sided Weakness/Paralysis and Anxiety.<br><br>The admission Minimum Data Set (MDS) assessment dated 12/3/10 identified Resident #15 as cognitively intact and needing extensive assistance to total dependence with all activities of daily living, except eating where she was assessed as needing set up only.<br><br>A review of the comprehensive care plan for Resident #15 revealed no documentation to show that the resident had been assessed to self administer medications.<br><br>Review of the Physician ' s orders did not reveal a physician order for (name of spray) nasal spray or for Resident #15 to self administer any medication. | F 176 | F 176<br><br>1 Resident #15 has been assessed for self administration of medication(s). See Attachment<br><br>2. Residents have been reviewed to determine the potential of others to self administer medications.<br>(No other occurrences were found.)<br><br>3. MDS Nurse, Floor Nurse, RN Supervisor, will monitor weekly for 3 weeks and then periodically to determine any Residents qualify for the potential of self administration of medication.<br><br>4. Monthly reviews will be discussed monthly during the QA meeting. The MDS Nurse and DON will ensure correction is achieved and maintained during the monthly QA meetings x 3 months. | 5-11-11<br><br>5-11-11<br><br>5-11-11<br><br>5-11-11 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Erin Mallard - Administrator | 5-6-11

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 176 | Continued From page 1<br>A review of the Interdisciplinary Progress Notes dated 3/17/11 documented that the CNA's (certified nursing assistant) discovered nineteen (19) bottles of nasal spray in Resident #15's closet. Further documented was that the Social Worker counseled the resident and told her she could not keep medications at her bedside unless this was ordered by the Physician. The medications were removed from the room.<br><br>During an observation on 4/13/11 at 11:50AM, Resident #15 was sitting in her bed with her bedside table next to her. On top of the bedside table was a bottle of (name of spray) nasal spray - Decongestant.<br><br>During an interview with Nurse # 1 on 4/13/11 at 11:55AM she stated that she was unaware that Resident #15 had any nasal spray. Nurse #1 reviewed the Medication Administration Record and there was no physician order for nasal spray.<br><br>During an interview with the Nurse Facilitator on 4/13/11 at 11:55AM, she stated that Resident #15 had originally been admitted to the rest home side of the facility but could not do things for herself and was transferred to the skilled nursing hall.<br><br>During an interview with the Director of Nursing (DON) on 4/13/11 at 12:00PM, she stated the facility had taken her nasal spray and she was not supposed to have any at her bedside.<br><br>During a second observation on 4/13/11 at 12:15PM, Resident #15 was sitting in her wheelchair with her bedside table in front of her and the nasal spray on the bedside table. The bottle read, " (name of spray) nasal spray, Decongestant. The active ingredient was | F 176 | | |

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| F 176 | Continued From page 2<br>Oxymethzoline Hydrochloride, which is used as a decongestant.<br><br>During an interview with Resident #15 at 12:15PM she stated that her fiancée had bought approximately 20 bottles of the nasal spray and brought it to her. She stated that the facility took most of the spray to store for her and left her one bottle. She further stated that as the bottles " got low " the nurse would bring a new bottle to her.<br><br>During an interview with the DON on 4/13/11 at 2:00PM, she stated that this type of nose drop is very addicting. She further stated that she talked with resident #15 and told her she could not have the medication at her bedside. She stated the Physician would be notified so the situation could be evaluated. | F 176 | | |
| F 250 SS=D | 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE<br><br>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, and staff interviews, the facility failed to arrange services to obtain a wheelchair battery for 1 of 1 sampled residents with an electric wheelchair. (Resident #3).<br><br>The findings are:<br><br>Resident #3 was originally admitted to the facility on 11/8/10 with diagnoses including Venous | F 250 | F 250<br><br>1. The facility has arranged services for Resident #3 to obtain wheelchair battery for personal electric wheelchair.<br><br>2. Social Worker has been in-services to follow up on medically-related social service needs of Residents to make sure they attain or maintain the highest practicable physical, mental, and psychosocial well-being.<br><br>3. Social Worker, MDS Nurse, DON, & Administrator will monitor for 3 months for potential medically related social service needs. Social Worker will provide contact information for services available & will assist with making contact if needed.<br><br>4. Monthly reviews will be discussed monthly during the QA meeting. The Administrator & Social Worker and DON will ensure correction is achieved and maintained during the monthly QA meetings x 3 months. | 5-11-11<br><br>5-11-11<br><br>5-11-11<br><br>5-11-11 |

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| F 250 | Continued From page 3<br>Thrombosis and Paraplegia. According to the most recent Quarterly Minimum Data Set dated 2/5/11, Resident #3's memory was intact. In the areas of bed mobility and transfers Resident #3 was coded as independent. In the area of ambulation or the ability to move from one place to another, both on and off of his unit, Resident #3 was coded as independent with the use of his electric wheelchair.<br><br>Review of a Social Work note dated 12/7/10, read, (Resident #3) "brought concern about his wheelchair not charging, explained to him that he will need to contact family or obtain money to pay for a new one. Ins. (insurance) will not cover the cost while he resides in SNF (Skilled Nursing Facility). (Resident #3) understands disposition. No further complaints offered at this time. (Resident #3) is able to mobilize for short periods of time, but chair does not maintain its charge."<br><br>During a group meeting on 4/11/11 at 2:00PM, Resident # 3 stated his wheelchair needed to be serviced because his battery was low. He revealed the facility Social Worker informed him that his insurance would not pay for his wheelchair to be serviced.<br><br>During an interview on 4/12/11 at 11:50AM, the facility Social Worker revealed the battery on Resident #3's electric wheelchair did not keep a charge for very long. She stated the resident's insurance would not pay for a new battery and the resident's family did not have money to pay for a new battery. She stated Resident #3 was still able to get around the facility in his wheelchair. The Social Worker revealed Resident #3 told her about his wheelchair needing a new battery about three months ago. She stated the resident told | F 250 | | |

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| F 250 | Continued From page 4<br>her that he did not have the money to pay for a new battery. She revealed that Resident #3 had not said anything more to her about his wheelchair since he talked to her about it three months ago. The Social Worker stated Resident #3 continued to go up and down the halls in his wheelchair. She revealed she did not know how long the resident's battery would last and she also did not know what would happen if the resident's electric wheelchair stopped completely. The Social Worker stated Resident #3 had money, but he did not want to spend it. She revealed she did not know how much a battery for the resident's wheelchair would cost. The Social Worker stated as long as the wheelchair was working, Resident #3's insurance would not pay for a new battery. She revealed the company that Resident #3 purchased the wheelchair would not replace the battery.<br><br>During an interview on 4/12/11 at 3:30PM, Resident #3 revealed he had checked with the company that had serviced his wheelchair and he was informed that his insurance would not pay for a new battery for his wheelchair. He stated he had the electric wheelchair for three years and the battery was replaced one time. He stated his insurance paid for a new battery because he was at home at the time. Resident #3 revealed when he got up in the morning he would ride around in his wheelchair for an hour and he would charge up his battery at 11:00AM and after lunch. He stated he charged his battery throughout the day. He stated his wheelchair slowed down when the battery needed to be charged. Resident #3 revealed that his electric wheelchair was his only means of transportation. He stated the Social Worker told him that his insurance would not pay for a new battery. He stated he did not know how | F 250 | | |

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| F 250 | Continued From page 5<br>much a new battery would cost because his insurance paid for a new battery when he was at home.<br><br>During an interview on 4/12/11 at 4:20PM, NA#6 stated Resident #3 was out of his room most of the time. She revealed Resident #3 charged his battery after 3:00PM, after supper and before bedtime.<br><br>During an interview on 4/13/11 at 11:20AM, the Administrator revealed the first time she learned about Resident #3 needing a new battery for his wheelchair was yesterday or the day before. She stated she would have to find out how much it would cost to replace the battery. She revealed the Social Worker would check to determine if there were donations other than family members. | F 250 | F 314<br><br>1. Facility has/will provide treatment as needed for Resident #1.<br><br>2. Staff will be in-serviced on documentation after administration of treatments for pressure ulcers by DON, & MDS Nurse and Floor Nurse.<br><br>3. DON, Medical Records, RN Supervisor, & Floor Nurse will monitor daily x 3 weeks and then 1x a week to ensure documentation and treatments are provided. Pharmacist will also help monitor during monthly visits to ensure documentation is documentation is completed accurately.<br><br>4. Monthly reviews will be discussed monthly during the QA meeting. The DON, MDS Nurse, and Administrator will ensure correction is achieved and maintained during the monthly QA meetings x3 months. | 5-11-11<br><br>5-11-11<br><br>5-11-11<br><br>5-11-11 |
| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews and medical record review the facility failed to provide treatment as ordered for one (1) of four (4) sampled residents with pressure ulcers. (Resident #1) | F 314 | | |

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| F 314 | Continued From page 6<br><br>Findings include:<br><br>Resident #1 was admitted to the facility on 1/7/11 with diagnoses of cervical cord contusion, neurogenic bladder and bowel.<br><br>A review of the resident ' s admission Minimum Data Set (MDS) dated as 1/14/11, revealed he had no long or short-term memory problems and was independent with cognitive skills for daily decision making. Resident #1 was total assistance for activities of daily living (ADLs).<br><br>A review of the care area assessment process (CAA), dated 1/20/11, revealed Resident #1 triggered for pressure ulcers due to diagnoses of a spinal cord injury, neurogenic bowel and bladder, neuropathic pain, and functional limitation in range of motion. Resident #1 was admitted with a pressure ulcer.<br><br>The current Plan of Care dated 1/20/11 addressed the problem of pressure ulcers with an approach to provide treatment as ordered.<br><br>Physician ' s orders dated 3/3/11 noted for both heels (plantar aspect) to apply betadine twice a day.<br><br>Record review of the treatment record for April, 2011 revealed Resident #1 did not receive treatments on 4/5/11 (7am shift) 4/9/11 (7am shift) and 4/10 (7 am shift).<br><br>Record review of the wound/ulcer flow sheet revealed that on 3/3/11 the left planter aspect of the heel was a blister measuring 3 centimeters (cm) by 3cm. Documentation revealed that on | F 314 | | |

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| F 314 | Continued From page 7<br>3/28/11 the area was scabbed measuring 2 cm by 2 cm. Documentation revealed on 4/11/11, the area remained scabbed and measured 2 cm by 2 cm. The treatment was to apply betadine twice a day<br><br>Record review of the wound/ulcer flow sheet revealed that on 3/7/11 the right planter aspect of the heel was a blister measuring 2.5cm by 2.5cm. Documentation revealed on 4/11/11, the heel area was assessed as scabbed and measured 2 cm by 2 cm. The treatment was to apply betadine twice a day.<br><br>During an interview on 4/12/11 at 8:25 am, Nurse #3 stated Resident #1 had a treatment to both of his heels to be done twice a day. She stated she did not know when she would do the treatment because the resident had physical therapy and she did not want to interfere. Nurse #3 stated all she had to do was to put the betadine on both of his heels and Resident #1 would let her know when he would be available.<br><br>During an interview on 4/12/11 at 9:38 am, Resident #1 stated he was not receiving his treatments to both of his heels every day. Resident #1 stated in order for him to get his treatments, he had to go and find the nurse.<br><br>During an interview on 4/13/11 at 12:25 am, Nurse #1 stated she had failed to document in the treatment record for April, 2011; and failed to document on 4/5/11 (7am shift) 4/9/11 (7am shift) and 4/10 (7 am shift). Nurse #1 stated she knew she had given the treatments because Resident #1 knew when he wanted his treatments done and would come and let her know. | F 314 | | |

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| F 314 | Continued From page 8<br>During an interview on 4/13/11 at 12:30 PM, the Director of Nursing (DON) stated when there was no documentation, the treatment could be considered as not having been done. The DON stated she did believe the treatment was done, due to the improvement of both heels and Resident #1 would come and get you when he wanted his treatments. | F 314 | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews the facility failed to properly store a portable oxygen cylinder in 1 of 1 room on the 300 hall (room #305).<br><br>Findings include:<br><br>Review of the Code of Federal Regulations (29 CFR 1910.101) revealed the storage and utilization of all compressed gases in cylinders or portable tanks shall be in accordance with Compressed Gas Association Pamphlet P-1-1965. Because of the potential for cylinder rupture if a cylinder is damaged Pamphlet P-1-1965 recommends "secure cylinders at all times to prevent tipping by using appropriate materials such as chains, plastic coated wires, or | F 323 | F 323<br><br>1. Portable oxygen cylinders are being properly stored in oxygen storage area.<br><br>2. In-Service Staff on proper storage techniques / storage area for oxygen cylinders.<br><br>3. Floor Nurses, DON, Maintenance Director, & Administrator will monitor daily x 3 wks. and then periodically to ensure oxygen cylinders are stored properly.<br><br>4. Monthly reviews will be discussed monthly during the QA meeting. The Administrator, DON, & Maintenance Director will ensure correction is achieved and maintained during the monthly QA meetings x 3 months. | 5-11-11<br><br>5-11-11<br><br>5-11-11<br><br>5-11-11 |

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| F 323 | Continued From page 9<br>commercial holders".<br><br>During the initial tour of the facility on 4/11/2011 at 10:55 AM a free standing upright standard portable oxygen cylinder was observed in room #305. The cylinder was located between the first bed's nightstand and the privacy curtain. The cylinder was observed to be directly on the floor with no stabilizing cart or stand.<br><br>The free standing upright oxygen cylinder was observed on 4/12/2011 at 8:15 AM and at 2:40 PM in room #305. There was no stabilizing cart or stand.<br><br>Review of the most current Minimum Data Set for the two residents in room #305 revealed no respiratory treatments or oxygen use.<br><br>During an interview with Nursing Assistant #1 on 4/12/2011 at 12:45 PM she revealed the oxygen cylinders were stored in a room at the nurse's station. She stated staff take the empty cylinder up to the storage area and bring the full cylinder back. The cylinders are placed in a cart or in the holders on the back of the facility's wheelchairs. She stated the cylinder should be in a holder because it can fall over and explode.<br><br>During an interview with Nurse #3 on 4/12/2011 at 3:10 PM she indicated portable oxygen cylinders are placed on the back of wheelchairs or in a wheeled cart. She stated no free standing or loose cylinders should be found in the facility. She revealed she had found "one or two" in the past in a resident's room. The nurse stated the cylinder should not be in the resident's room without some stabilizing holder due to the danger if the cylinder should fall over. | F 323 | | |

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| F 323 | Continued From page 10<br><br>An interview was conducted with the facility Administrator on 4/12/2011 at 4:10 PM. The Administrator revealed the facility did not have a written policy on how to store portable oxygen cylinders. She stated staff were informed where the oxygen storage room was. She indicated staff were instructed in the dangers of explosion with mishandled cylinders and were aware of federal requirements. She revealed it was her expectation staff would bring an empty cylinder down to the storage room, remove the tubing, and place the cylinder in the empty slots of the storage bin. The administrator indicated staff should remove a full cylinder, reapply the tubing, adjust the oxygen flow per doctor's orders, and then place the cylinder in the wheelchair holder or in a rolling cart. | F 323 | | |
| F 328 SS=D | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS<br><br>The facility must ensure that residents receive proper treatment and care for the following special services:<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care;<br>Tracheal suctioning;<br>Respiratory care;<br>Foot care; and<br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews, and medical record reviews the facility failed to provide humidified oxygen water to 1 of 2 | F 328 | F 328<br><br>1. Humidifier oxygen water was provided to Resident # 16.<br><br>2. In-Service Nurses on replacement of humidifier oxygen water for tracheotomy Residents.<br><br>3. DON, MDS Nurse, RN Supervisors, & Floor Nurses will monitor daily q shift on MAR's to ensure humidifier oxygen water is in place for all tracheotomy Residents.<br><br>4. Monthly reviews will be discussed monthly during the QA meeting. The DON & MDS Nurse will ensure correction is achieved and maintained during the monthly QA meetings x 3 months. | 5-11-11<br>5-11-11<br>5-11-11<br>5-11-11 |

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| F 328 | Continued From page 11<br>tracheotomy residents (Resident # 16).<br><br>Findings include:<br><br>Resident #16 was admitted to the facility on 9/1/2004. The resident had cumulative diagnosis of Respiratory Failure, Stroke with left sided paralysis, Dementia, Seizure Disorder, Diabetes type 2, a tracheotomy, and a gastric tube.<br><br>A review of Resident #16's most recent Minimum Data Set (MDS) dated 2/9/2011 revealed the resident was severely impaired in mobility and daily activities.. The resident was totally dependent on staff for all areas of care and was bedfast. Resident # 16 had moderately impaired speech which made it difficult for him to communicate his needs to staff. The resident was not able to use a call bell.<br><br>A review of the resident's medical record indicated he was dependent on oxygen administered through a tracheotomy. A doctor's order dated 12/8/2010 at 9:00 PM instructed the resident to receive oxygen via a trach shield with 30% humidified air. A review of the resident's care plan dated 4/4/2011 revealed the facility was to provide humidity to prevent dryness of mucous membranes. A second planned intervention was for oxygen continuous @ 5 liters humidified @ 33%.<br><br>During a walk through of the facility 300 Hall on 4/11/11 at 4:35 PM Resident #16 was observed lying in his bed. Oxygen was observed being administered via a trach shield but the water bottle which supplied humidification was empty. A second walk through at 4: 55 PM revealed the bottle remained empty. | F 328 | | |

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| F 328 | Continued From page 12<br><br>During an interview with Nursing Assistant #2 (NA) on 4/11/2011 at 5:00 PM she stated the bottle was suppose to have water in it. The NA indicated she would go find the nurse to put water in the bottle.<br><br>Nurse #3 was observed on 4/11/2011 at 5:10 PM to be at her medication cart administering evening meds. She stated she was going to fill the water bottle and indicated it was used with the oxygen to provide humidification which prevented nasal passages from drying out.<br><br>On 4/12/2011 at 5:25 PM Resident #16's water bottle was observed to be completely dry. A second observation at 5:45 PM revealed the bottle remained empty. Nurse #4 was notified and the bottle was filled.<br><br>During an interview on 4/13/2011 at 9:05 AM Nursing Assistant #3 revealed she often took care of Resident #16. She stated the resident was not able to use his call bell. The NA reported that staff watch the water bottles on oxygen concentrators and tracheotomies and let the nurse know when the water is low so it can be refilled.<br><br>Nurse #4 was interviewed on 4/13/2011 at 10:25 AM. The nurse indicated the facility policy for humidified oxygen was to change out the tubing and bottle each week. She stated staff watch the humidity bottle and fill it with distilled water as needed. Nurse #4 revealed Resident#16 was not able to use a call bell. She stated staff had to anticipate his needs.<br><br>During an interview with the Director of Nursing | F 328 | | |

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| F 328 | Continued From page 13<br>(DON) on 4/13/2011 at 11:45 AM she revealed she was not aware Resident #16's water bottle had been observed empty the past two evenings. The DON indicated it was her expectation staff would continuously check the humidifier bottle during resident care and replace the water as needed and prior to the bottle being empty. | F 328 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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. | F 441 | F 441<br><br>1. The facility will ensure soiled linen is handled & stored in a manner to prevent the spread of infection by not placing linens on the floor.<br><br>2. In-Service Nursing Staff on proper procedures of placing soiled linen in plastic bag & then placing in dirty linen barrel.<br><br>3. Floor Nurses, DON, MDS Nurse, & RN Supervisors will monitor daily x 3 weeks then periodically to ensure soiled linen is handled properly.<br><br>4. Monthly reviews will be discussed monthly during the QA meeting. The DON, MDS Nurse, and Administrator will ensure correction is achieved and maintained during the monthly QA meetings x 3 months. | 5-11-11<br><br>5-11-11<br><br>5-11-11<br><br>5-11-11 |

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| F 441 | Continued From page 14<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to ensure soiled linen was handled and stored in a manner to prevent the spread of infection by placing linen on the floor of 2 of 20 rooms on the 100 hall (room 121 and room 129).<br><br>The findings are:<br><br>1. Review of an undated facility policy, titled, "Policy and Procedure Handling soiled Linen," under Policy, read in part, "Soiled linen will be handled and stored in a way that avoids the transfer of organisms to other residents/the environment." Under Procedure, read in part, " 2. Use plastic bag to place soiled linen in after removing soiled linen from the resident's bed. 3. Strip bed carefully, with least shaking as possible. Fold linen from outer edges toward center of bed. Roll into a bundle and place in the plastic bag. 5. Do not place soiled linen on furniture, floor, or other surfaces."<br><br>During the initial tour of the facility on 4/11/11 at 11:10AM, an observation of room 121 revealed a bundle of linen and clothing on the floor of the room. NA#4 came into the room picked up the linen from the floor and placed the linen in a barrel outside of the room. | F 441 | | |

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| F 441 | Continued From page 15<br>During an interview on 4/11/11 at 11:15AM, Nursing Assistant (NA) #4 revealed she normally placed linen on the floor and then placed them in a linen barrel.<br><br>During an interview on 4/13/11 at 11:15AM, the Director of Nursing (DON) revealed when staff have a small amount of linen the linen should be placed in a linen barrel outside of the resident's room. She stated if staff removed a lot of linen from a resident's room, the linen should be placed in a trash bag or pillow case and put in a linen barrel. She stated hospice aides had also been told to put linen in trash bags. The DON revealed a huge training session on handling linens was held recently.<br><br>2. Review of an undated facility policy, titled, "Policy and Procedure Handling soiled Linen," under Policy, read in part, "Soiled linen will be handled and stored in a way that avoids the transfer of organisms to other residents/the environment." Under Procedure, read in part, " 2. Use plastic bag to place soiled linen in after removing soiled linen from the resident's bed. 3. Strip bed carefully, with least shaking as possible. Fold linen from outer edges toward center of bed. Roll into a bundle and place in the plastic bag. 5. Do not place soiled linen on furniture, floor, or other surfaces."<br><br>During an observation on 04/13/2011 at 8:15 a.m. in room #2 NA #4 was observed to be standing over a pile of soiled bed linens, towels and washcloths on the floor. NA #4 picked up soiled linen with ungloved hands, opened the door and placed the soiled linen in the receptacle in the dirty utility room for dirty linen. | F 441 | | |

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| F 441 | Continued From page 16<br><br>During an interview on 04/13/2011 at 8:20 a.m. NA #4 indicated that she should have placed the dirty linen in a bag but she did not see one in the room and placed the linen on the floor.<br><br>During an interview, by telephone, on 04/13/2011 at 8:20 a.m. with NA #4 ' s Supervisor she stated that her expectations were for NA #4 to follow the facility ' s protocol for handling dirty linen.<br><br>During an interview on 4/13/11 at 11:15 a.m. the Director of Nursing (DON) revealed when staff have a small amount of linen the linen should be placed in a linen barrel outside of the resident ' s room. She stated if staff remove a lot of linen from a resident ' s room, the linen should be placed in a trash bag or pillow case and put in a linen barrel. She stated hospice aides had also been told to put linen in trash bags. The DON revealed that a huge training session on handling linens was held recently. | F 441 | | |