| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| WILLOW RIDGE OF NC LLC | 237 TRYON ROAD RUTHERFORDTON, NC 28139 |

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| F 000 | INITIAL COMMENTS<br><br>No deficiencies were cited as a result of the Complaint Investigation Survey of 05/04/11. Event ID #FO7K11. | F 000 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* | |
| F 310 SS=D | 483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident interview, staff interviews and medical record review the facility failed to implement measures for one (1) of five (5) sampled residents to maintain their ability to effectively communicate. (Resident #7)<br><br>The Findings are:<br><br>Resident #7 was admitted to the facility with diagnoses that included cerebrovascular accident and right hemiparesis. Resident #7 was assessed on her Minimum Data Set (MDS) dated 03/31/11 as having moderate cognitive impairment, needing extensive assistance for care, having unclear speech, being sometimes understood and as usually understanding. Resident #7 was not coded on the MDS as having received speech and language pathology services. The resident's | F 310 | **F- 310**<br>**1.) How corrective action will be accomplished for the resident affected:**<br><br>**R#7 remains in the nursing center. R#7 communication status was evaluated by Speech Therapy on May 16th and picked up for therapy. Result of Speech Evaluation as follows: "responds to yes/no question with severe impairment", and "demonstrates ability to follow 1 step directions with severe level of impairment." SLP note states "due to severity of receptive and expressive language skills patient does not utilize communication board at this time." Speech Therapy sessions were attempted and the resident did not participate. Occupational Therapy progress note on May 18 states "provided resident with communication board with pic of a variety of needs and wants, resident unable to identify any of the objects" and "several times resident was asked to show where something was and not one time was resident able to point to the correct one". Resident's admission diagnosis included multiple CVA and supports that R#7 has declined in cognition and communicative skills. Medical Director** | 6/1/11 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: ✓ Reginald J. Faddoul — TITLE: ✓ Administrator — (X6) DATE: ✓ 5/26/2011

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.

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| F 310 | Continued From page 1<br>Care Area Assessment (CAAs) dated 04/05/11 specified that the area of "Communication" was triggered for further staff review and would be care planned.<br><br>Resident #7's care plan dated 03/28/11 contained a "problem", which specified the resident had a potential for altered communication. The care plan goal specified the resident would remain free from injury. Interventions for this problem included; assess communication, speak clearly, validate understanding and anticipate needs. The care plan further revealed an intervention for speech therapy to evaluate and treat as indicated.<br><br>Review of Speech Therapy documentation revealed that a screening was performed by the speech therapist on 04/13/11. The screening form specified that Resident #7 had severe speech apraxia and that speech therapy would not be done with the resident.<br><br>An observation on 05/02/11 at 12:40 PM revealed Resident #7 was in bed. When Resident #7 was spoken to she did not answer verbally, but her eyes were very expressive, she pursed her lips together and tried to speak.<br><br>An observation on 05/02/11 at 2:08 PM revealed Resident #7 was seated in her wheel chair. When Resident #7 was spoken to she did not answer verbally, but her eyes were again expressive and when asked if she needed something she indicated that she did by nodding her head. Resident #7 was asked several questions, when asked if she needed to go to the bathroom she forced out the word "yes." Nursing Assistant (NA) staff were notified and took Resident #7 to | F 310 | **note on April 20 states "she is non-verbal due to previous CVA" and "On review of systems, she is aphasic really from her previous CVA." In addition the MD states "She can occasionally voice an expression and nod her head, but she has significant dysarthria so her orientation is difficult to obtain." An updated MD note on May 25th states "it is impossible to ascertain if she has much in the way of understanding or cognitive function. Today she is the same, completely aphasic and this is all related to her multiple ischemic strokes." "I think a decline in her function is unavoidable and any meaningful recovery is not to be expected." The FNP note on May 2nd states, "She is up in a wheelchair and does not answer any questions verbally. It looks like she tries, but she just cannot get anything out. She does shake her head a little bit, but not enough to let you know if she understands what you are talking about." A Significant Correction of the last 30-day assessment was made reflecting current clinical status of resident as relates to cognition and speech. Plan of Care re-established goals for staff to be able to identify "non-verbal" signs of stress or discomfort as well as needs and wants. Staff continues to anticipate needs based on diagnosis and non-verbal cues. R#7 removed from the interviewable list. A communication board of picture aides for ADLs and other needs implemented on May 10th and remain available for use by staff and resident. Direct care staff educated on specific communication efforts for R#7 to include awareness of non-verbal signs of attempts to communicate needs.** | 6/1/11 |



RJ Fabbro 5/26/2011

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| F 310 | Continued From page 2<br>the bathroom.<br><br>On 05/03/11 at 10:45 AM an interview was conducted with Licensed Nurse (LN) #4. When LN #4 was asked how staff communicated with Resident #7 she reported that the resident groans or they go by her facial expressions.<br><br>An interview was conducted on 05/03/11 at 1:20 PM with the Rehab Director. The Rehab Director indicated that according to the speech therapist's assessment he did not plan to work with Resident #7.<br><br>An interview with the Speech Therapist (ST) was conducted on 05/03/11 at 1:33 PM. The ST indicated that Resident #7 has severe speech apraxia. He reported the resident would not be appropriate for a communication board as Resident #7's cognition is good and staff could just run through a series of yes and no questions to communicate with her.<br><br>An interview was conducted on 05/03/11 at 1:55 PM with Licensed Nurse (LN) #5 who worked with Resident #7. LN #5 specified that Resident #7 gets very frustrated with communication. LN #5 stated that Resident #7 was able to answer yes and no questions. She further reported that Resident #7 liked to be out in the hall around other people. LN #5 stated that staff had tried to give Resident #7 a pencil to write messages, but she was unable to write with her left hand. LN #5 also stated that Resident #7 would benefit from using pictures or a notebook with different things written down so she could communicate better.<br><br>An interview was conducted on 05/04/11 at 11:00 | F 310 | **2.) How corrective action will be accomplished for those residents having the potential to be affected:**<br><br>**Residents with communications difficulties are potentially affected. In-service training conducted by the DON or designee for Social Worker & nurse staff focusing on assessing the communication needs and increasing the awareness of non-verbal signs of stress, discomfort and attempts to communicate needs or wants. Audit completed of care plans for residents with communication difficulties for appropriate communication goals, and correct MDS or Care Plan as indicated or needed.**<br><br>**3.) What measures will be put in place or systemic changes made to ensure correction:**<br>**Social Worker completes Assessment Tool for hearing, speech & vision and documents in electronic chart identifying communication problems and need for referral to Speech, OT or PT as needed for hearing, vision as well as speech. Therapy, Care Plan Team and MDS Coordinator reviews procedures for admissions assessments upon admission and at each subsequent quarterly assessment, and when appropriate provides residents with communication devices to improve their over-all well being, and creating resident centered care plans by implementing specific interventions to improve their communication needs. The DON or designee will create and maintain an accurate list of residents with communication difficulties, and develop and implement a QA Communication** | 6/1/11 |



R Fadden
5/26/2011

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| F 310 | Continued From page 3<br>AM with the Director of Nursing (DON). The DON reported that what they currently had in place for Resident #7 to communicate was not adequate. The DON stated that the staff needed to take more initiative to assess what would work to provide Resident #7 with more contact and to be able to communicate more effectively. | F 310 | **Audit Tool. This QA Tool will be used to audit the communication difficulty list once weekly for four weeks, and then once monthly for three months.**<br>**4.) How the facility plans to monitor its performance to make sure that solutions are ensured:** | 6/1/11 |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and medical record reviews the facility failed use proper technique while providing incontinence care for one (1) of two (2) sampled residents. (Resident #6)<br><br>The findings are:<br><br>Review of the facility's policy entitled "Perineal Care", which was revised in September 2005, revealed the the following procedural steps for cleaning a female resident:<br><br>9 a. Wet washcloth and apply soap or skin | F 315 | **The Social Worker or designee will compile audit results and present to the Quality Assurance Committee Meeting quarterly. Subsequent plans of action developed as indicated by the Committee. The Administrator is responsible for overall compliance.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*<br><br>**F- 315**<br>**1.) How corrective action will be accomplished for the resident affected:**<br><br>**R#6 was provided proper incontinence care and experiences no adverse signs or symptoms of UTI. NA #1 & #2 were re-educated on providing proper incontinence care by the SDC and DON. NA's working were provided incontinence care education on during the survey by Nurse Management and according to the facility Policy and Procedure for incontinence care.** | 6/1/11 |



R Fedder 5/26/11

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| F 315 | Continued From page 4<br>cleansing agent.<br>b. Wash the perineal area, wiping front to back.<br>(1) Separate Labia and wash downward from front to back.<br>(2) Continue to wash the perineum from inside outward including the thighs alternating from side to side, and using downward strokes.<br>(3) Rinse perineum thoroughly in the same direction, using water and a clean washcloth.<br>(4) Gently dry perineum.<br><br>Resident #6, a female resident, was admitted to the facility with diagnoses that included dementia, diabetes and hypertension. Review of Resident #6's Minimum Data Set (MDS) dated 03/08/11 revealed she was cognitively impaired. The MDS further revealed that Resident #6 needed extensive assistance with activities of daily living which included assistance with toileting.<br><br>Review of the Resident #6's lab results revealed a urine culture and sensitivity was performed on 03/14/11. The results of this urinalysis specified that Resident #6 had a urinary tract infection which was positive with Ecoli. A notation on this laboratory report specified that the resident's urinary tract infection was to be treated with Macrobid.<br><br>Resident #6's care plan dated 03/16/11 contained a "problem" which identified the resident as having a potential for urinary tract infections. The goal for this "problem" specified that the resident would remain free from signs and symptoms of urinary tract infection. An approach within this plan of care specified; "provide pericare when incontinent." | F 315 | **2.) How corrective action will be accomplished for those residents having the potential to be affected:**<br><br>**NA's in facility provided education on the facility incontinence care P&P. Return demonstration of incontinence care observed by Nurse Management for NA's. Nurse Managers will conduct random rounds while in the facility and observe one NA completing Incontinence Care by using the QA Peri-Care Tool.**<br><br>**3.) What measures will be put in place or systemic changes made to ensure correction:**<br><br>**Nurse managers will conduct at least one daily observation of incontinence care by a NA daily using the QA Peri-Care Tool for three weeks and then twice weekly for two weeks and then once per month for four months. The DON will review all QA audits for discrepancies and direct appropriate corrective actions. In-service education will be conducted at least quarterly on incontinence care techniques and infection control.**<br><br>**4.) How the facility plans to monitor its performance to make sure that solutions are ensured:**<br><br>**The DON or designee will compile audit results and present to the Quality Assurance Committee Meeting quarterly. Subsequent plans of action developed as indicated by the Committee. The Director of Nursing is responsible for overall compliance.** | 6/1/11 |



R Fiddler 5/26/11

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| F 315 | Continued From page 5<br><br>An observation on 05/03/11 at 10:25 AM revealed Nursing Assistant (NA) #1 and NA #2 were providing incontinence care to Resident #6. NA#1 and NA #2 used a sit to stand lift to stand Resident #6 while they performed incontinence care. Resident #6's incontinence brief was removed by staff and NA #1 used a wet washcloth to wash Resident #6's perineal area. NA #1 cleaned the resident's perineal area by making three wipes from the resident's anal area toward and over her labial area with the wet washcloth.<br><br>An interview was conducted on 05/03/11 at 1:03 PM with NA #1. NA #1 reported that when providing incontinence care to Resident #6 she should not have wiped from the resident's anal area toward and over the resident's labial area. NA #1 specified that she should have instead cleaned the resident's perineal area by wiping the resident from "front to back."<br><br>An interview was conducted with the Director of Nursing (DON) on 05/03/11 at 1:00 PM. The DON reported that NA #1 should have used the technique of cleaning Resident #6's perineal area by wiping from "front to back". | F 315 | | 6/1/11 |
| F 332 SS=D | 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE<br><br>The facility must ensure that it is free of medication error rates of five percent or greater.<br><br>This REQUIREMENT is not met as evidenced by: | F 332 | | |



5/26/11

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| F 332 | Continued From page 6<br>Based on observations, staff interviews and medical record reviews, the facility failed to maintain a medication administration error rate of less than five (5) percent by not administering medications as ordered by the physician. During four (4) medication passes three (3) errors were detected in a total fifty-four (54) opportunities resulting in a 5.55 percent error rate. (Residents #4, #25 and #26).<br><br>The findings are:<br><br>1. During observation of a medication pass on 05/02/11 at 5:15 p.m. Licensed Nurse (LN) #1 administered Systane eye drops to Resident #25. LN #1 administered one drop into the resident's right eye and two (2) drops into the resident's left eye.<br><br>A review of Resident #25's monthly physician's orders dated May 1 - 31, 2011 revealed an order for Systane eye drops one (1) drop to each eye four times per day.<br><br>During an interview with LN #1 on 05/02/11 at 5:52 p.m. she recalled talking to Resident #25 about her red and watery eyes while administering the eye drops and didn't realize that she administered two drops in the resident's left eye.<br><br>An interview with the Director of Nurses (DON) on 05/04/11 at 11:12 a.m. revealed she expected nursing staff to look at physician's orders and administer medications as ordered. The DON confirmed that LN #1 failed to correctly administer Resident #25's Systane eye drops as ordered by the physician by placing two drops into her left | F 332 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*<br><br>**F- 332**<br>**1.) How corrective action will be accomplished for the resident affected:**<br><br>**R#4 and R#25 suffered no adverse outcomes related to the medication error and LN#1 was educated on properly following MD orders. R#26 suffered no adverse outcomes related to the medication error and LN#2 was educated on properly following MD orders.**<br><br>**2.) How corrective action will be accomplished for those residents having the potential to be affected:**<br><br>**No other residents were identified during the survey. All residents are potentially affected by similar deficient practices. Licensed nurses were in-serviced by the SDC or designee for Medication Administration Policies and administering medications according to MD orders.**<br><br>**3.) What measures will be put in place or systemic changes made to ensure correction:**<br><br>**Nurse Managers will each conduct two random Medication Administration** | 6/1/11 |



RJ Fadden 5/26/11

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| F 332 | Continued From page 7<br>eye.<br><br>2. During observations of a medication pass on 05/02/11 at 5:35 p.m. Licensed Nurse (LN) #1 administered twenty-five (25) milligrams of Coreg by mouth to Resident #4 along with one-half cup of water. LN #1 did not provide Resident #4 with any food during this medication administration. On 05/02/11 at 5:36 p.m. Resident #4 rolled his wheelchair into the hallway and stated he was going to the smoking area. On 05/02/11 at 5:58 p.m. Resident #4's evening meal tray was observed on the overbed table in his room, none of the containers had been opened and Resident #4 was not in his room.<br><br>A review of Resident #4's monthly physician orders dated May 1 - 31, 2011 revealed an order for Coreg 12.5 milligrams to be given twice daily with meals.<br><br>An interview with Licensed Nurse (LN) #1 on 05/02/11 at 5:54 p.m. revealed she did not think about giving Resident #4's medication with food and did not know if Resident #4 had eaten his evening meal.<br><br>An interview with the Director of Nurses (DON) on 05/04/11 at 11:12 a.m. revealed she expected nursing staff to look at physician's orders and administer medications as ordered. The DON confirmed that LN #1 should have administered Coreg to Resident #4 on 05/02/11 with food as ordered by the physician.<br><br>3. During observations of a medication pass on 05/03/11 at 4:26 p.m. Licensed Nurse (LN) #2 administered 25 milligrams of Phenergan by | F 332 | **Reviews using the Medication Administration Audit weekly for three weeks and then the DON or designee will ensure one audit of medication administration per week for six weeks. The Pharmacist will continue to conduct random audits upon each visit and provide observations and guidance to the DON. Medication administration in-services will continue at least quarterly for licensed nurses.**<br><br>**4.) How the facility plans to monitor its performance to make sure that solutions are ensured:**<br><br>**The DON or designee will compile audit results of Medication Administration Tools and present to the Quality Assurance Committee Meeting quarterly. Subsequent plans of action developed as indicated by the Committee. The Director of Nursing is responsible for overall compliance.** | 6/1/11 |



R Faddon
5/26/11

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| F 332 | Continued From page 8<br>mouth to Resident #26. During this medication administration LN #2 was observed to provide Resident # 26 with only one-half cup of water to take with the Phenergan. LN #2 did not provide the resident with any type of food to take with the Phenergan.<br><br>A review of Resident #26's monthly physician's orders dated May 1 - 31, 2011 revealed an order for Phenergan 25 milligrams orally to be given with meals.<br><br>An interview with LN #2 on 05/03/11 at 4:54 p.m. revealed she often mixed apple sauce with medications but did not think to give Resident #26 any food with his Phenergan. LN #2 verified the evening meal had not been served and Resident #26 had not received any food since she administered the Phenergan.<br><br>An interview with the Director of Nurses (DON) on 05/04/11 at 11:12 a.m. revealed she expected nursing staff to look at physician's orders and administer medications as ordered. The DON confirmed that LN #2 should have administered Phenergan to Resident #26 on 05/03/11 with food as ordered by the physician. | F 332 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* | 6/1/11 |
| F 425 SS=D | 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. | F 425 | **F- 425**<br>**1.) How corrective action will be accomplished for the resident affected:**<br><br>**No residents were identified in the CMS-2567, and would only be at risk if gaining access to the unlocked medication cart. LN#1 was re-educated on the facility's policy on locking the medication carts when unsupervised. Medication carts were verified as being locked.** | |



R Faddon 5/26/11

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| F 425 | Continued From page 9<br>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews the facility failed ensure that one (1) of four (4) medication carts, with the medications stored inside of them, were locked when left unattended by staff.<br><br>The findings are:<br><br>On 05/02/11 at 5:28 p.m. Licensed Nurse (LN) #1 was observed getting supplies out of a medication cart to draw up insulin for a resident but no insulin syringes were in the medication cart. LN #1 stated she needed to go to a supply room to get insulin syringes. On 05/28/11 at 5:28 p.m. LN #1 was observed to walk away from the unlocked medication cart and to walk out of view of the cart. Continuous observations of the medication cart on 05/02/11 from 5:28 p.m. to 5:32 p.m. revealed it remained unlocked and unattended with medications accessible in the cart's drawers. During this continuous observation residents and visitors were observed | F 425 | **2.) How corrective action will be accomplished for those residents having the potential to be affected:**<br><br>**An audit of all medication carts conducted to assure that all medication carts are locked when unsupervised. Licensed nurses educated on facility policy for locking unsupervised medication carts.**<br><br>**3.) What measures will be put in place or systemic changes made to ensure correction:**<br><br>**The DON or designee will re-educate the licensed staff regarding locking of medication carts. The DNS or designee will monitor carts being locked through direct observation review for all carts 2x weekly for 4 weeks, then monthly x3 months for ongoing compliance. Employees will be in-serviced and re-educated as necessary to assure compliance with the facility policy. The SDC will include the policy on locking of carts in the orientation of new nursing personnel**<br><br>**4.) How the facility plans to monitor its performance to make sure that solutions are ensured:**<br><br>**Audit results will be reviewed and analyzed monthly for three months and then quarterly at the Quality Assurance Committee Meeting with subsequent plan of action developed and implemented as indicated. The Director of Nursing is responsible for overall compliance.** | 6/1/11 |



R J Fadden
5/26/11

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| F 425 | Continued From page 10<br>walking in the hallway in close proximity to the unlocked medication cart. On 05/02/11 at 5:32 p.m. LN #1 was observed to return to the medication cart and she locked the cart at this time.<br><br>On 05/02/11 at 5:32 p.m. LN #1 confirmed she did not lock the medication cart and had left the cart unattended while she went to look for insulin syringes. LN #1 stated that she was used to medication carts that self-locked but confirmed she should have locked the medication cart before leaving it unattended.<br><br>On 05/04/11 at 11:12 a.m. an interview with the Director of Nurses (DON) revealed her expectation was nursing staff should always lock a medication cart before leaving it unattended in order to prevent medications stored inside of the cart from being accessible. | F 425 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* | |
| F 441 SS=E | 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. | F 441 | **F- 441**<br>**1.) How corrective action will be accomplished for the resident affected:**<br><br>**R#4 and R#9 suffered no adverse outcomes as a result of the deficient practices and surrounding surfaces were properly cleaned and sanitized. R#14 suffered no negative outcome related to this deficiency. R#27 experienced no adverse outcome as a result of this deficiency and the glucometer was properly leaned at the time of survey. LN#1, LN#2 and LN#3 were educated by the DON and SDC on facility infection control policies and procedures. No further discrepancies were noted.** | 6/1/11 |



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| F 441 | Continued From page 11<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.<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 observation, staff interviews and medical record review, the facility staff failed to protect the surrounding surfaces while doing dressing changes on two (2) residents (Residents #4 and #9), clean the individual glucometer for one (1) resident (Resident #27) and dispose of dirty gloves prior to providing care for one (1) resident (Resident #14) in a sample of nine (9) residents.<br><br>The findings are:<br><br>Review of the facility's Infection Control Policy and Procedures, which were revised on August | F 441 | **2.) How corrective action will be accomplished for those residents having the potential to be affected:**<br><br>**All residents are potentially affected by deficient infection control procedures. Nursing staff were in-serviced by SDC on the facility policy for cleaning of Glucometers per manufacturer's instructions after use, the type of cleaning products required for cleaning Glucometers, facility dressing change and wound care policy and procedures, and the facility infection control policy.**<br><br>**3.) What measures will be put in place or systemic changes made to ensure correction:**<br><br>**Infection control in-services for staff will be conducted at least quarterly. The DON or designee will complete three random visual audits per week to ensure Glucometers are being cleaned per facility policy using the Medication Administration Audit Tool and by using the Infection Control QA Tool that dressing changes are being changed per policy. These observations will be done three time per week for four weeks, then once per week for three weeks followed by once monthly for three months. Any discrepancies will be noted by the DON and corrections made accordingly. Facility staff will be educated on Infection Control Policies at least quarterly.** | 6/1/11 |



RJ Faddon
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| F 441 | Continued From page 12<br>2007, specified; "1. Standard Precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. Standard Precautions apply to blood, body fluids, secretions, and excretions regardless of whether or not they contain visible blood, non-intact skin, and/or mucous membranes.<br>2. Transmission-Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent the spread of infection."<br><br>1. Resident #4 was admitted to the facility from a hospital with diagnoses of Methicillin-Resistant Staphylococcus Aureus (MRSA), diabetes mellitus, high blood pressure and arteriosclerosis. A review of the admission Minimum Data Set (MDS) dated 02/28/11 revealed the resident had short and long term memory problems and severe impairment in cognition.<br><br>A review of physician orders dated 03/25/11 revealed contact isolation for Methicillin-Resistant Staphylococcus Aureus (MRSA) in an ankle wound on Resident #4's left (L) foot. Orders dated 03/30/11 stated for wound vac dressing on (L) ankle to be changed on Monday, Wednesday and Friday each week and orders dated 05/03/11 stated to discontinue Vancomycin 1000 milligrams and start Vancomycin 1250 milligrams intravenously every 24 hours.<br><br>A review of Resident #4's plan of care dated 03/25/11 for impairment of skin integrity stated to continue wound vac as ordered and change dressing as ordered. | F 441 | **4.) How the facility plans to monitor its performance to make sure that solutions are ensured:**<br><br>**Audit results will be reviewed and analyzed monthly for three months and then quarterly at the Quality Assurance Committee Meeting with subsequent plan of action developed and implemented as indicated. The Director of Nursing is responsible for overall compliance.** | 6/1/11 |



RJ Faddon 5/26/11

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| F 441 | Continued From page 13<br>On 05/03/11 at 2:18 p.m. Licensed Nurse (LN) #3 put on an isolation gown, washed her hands, put on gloves, and knelt down on the floor in front of Resident #4 while he sat in his wheelchair in his room. LN #3 stated the wound vac was not functioning and wound drainage was collecting in the dressing. Resident #4 was holding his left leg up off the floor and had a large transparent dressing covering his left lower leg, ankle and foot with pooling of drainage visible in the bottom of the dressing under his heel. LN #3 removed the transparent dressing and wound drainage spilled onto the floor. LN #3 got paper towels out of the towel dispenser and placed them on the floor to catch the drainage. LN #3 picked up the paper towels on the floor and put them into a trash bag, removed gloves, and washed her hands. Clear drainage from Resident #4's left ankle continued to drip onto the floor. LN #3 put on clean gloves and cleaned the wound on Resident #4's left ankle with gauze saturated with normal saline, placed a saline dressing inside the wound, applied a transparent dressing over the top of the dressings and re-attached the wound vac tubing and turned the unit on. LN #3 removed her gloves, gown and put them into the trash bag. She tied off the bag, washed her hands and took the trash to the soiled utility room for disposal. A staff member from the therapy department entered the room to take Resident #4 for therapy and walked around his wheelchair where the drainage had spilled onto the floor.<br><br>On 05/03/11 at 2:40 p.m. during an interview with LN #3 she stated that she should have put a protective barrier on the floor to catch the drainage before she removed the dressing on Resident # 4's left ankle. She stated that she | F 441 | | 6/1/11 |



R Faddis 5/26/11

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| F 441 | Continued From page 14<br>would get housekeeping to mop the floor where the drainage spilled onto the floor. LN #3 called housekeeping and stated she was told they had left for the day. She called for a housekeeping supervisor and stated that she was told the mop water had disinfectant in it and she could use it to mop the floor. LN #3 stated that she was not sure she should use the mop and went to the nurse's station to look for a spill kit. LN #3 asked the DON at the nurse's station where a spill kit was located and was told to get one out of the bottom of the crash cart or use bleach solution located in the closet at the nurse's station.<br><br>On 05/03/11 at 2:45 p.m. during an interview with the Director of Nurses (DON) she stated the nurse should have put a barrier on the floor under the dressing before doing the dressing change to prevent spillage of drainage onto the floor and cleaning should have been done immediately to prevent the spread of infection. She further stated the nurse should have known where the spill kits or bleach solution were located and how to use them.<br><br>On 05/04/11 at 10:24 a.m. an interview with the Staff Development Coordinator (SDC) in charge of infection control in the facility and the DON revealed nursing staff should have placed a barrier on the floor when doing dressing changes to prevent spillage of drainage on the floor and keep resident's feet with open wounds from touching the bare floor. The SDC and DON stated the nurse should have cleaned drainage spilled onto the floor immediately by using a spill kit located in the crash carts or use a bleach solution located in the closet at the nurse's station to prevent the spread of infection. The DON stated | F 441 | | 6/1/11 |



RJ Fedder
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| F 441 | Continued From page 15<br>there was a housekeeper on second shift who should have assisted the nurse.<br><br>2. Resident #14 was admitted to the facility with diagnoses of type II diabetes mellitus and diabetic neuropathy. A review of the admission Minimum Data Set (MDS) dated 04/08/11 revealed the resident had short and long term memory problems and severe cognitive impairment. A review of physician orders revealed Resident #14 was to receive finger stick blood sugars before meals and at bedtime.<br><br>On 05/02/11 at 5:21 p.m. Licensed Nurse (LN) #1 was observed to remove two (2) gloves from a dispenser on the wall in Resident #14's room to do a finger stick blood sugar during a medication pass. LN #1 dropped one of the gloves onto the floor, reached down, picked it up and put it on her hand. LN #1 then walked over to the resident sitting in a geri chair and performed a finger stick blood sugar on the resident.<br><br>On 05/02/11 at 5:50 p.m. an interview with LN #1 revealed she stated she should not have put the glove on after she dropped it onto the floor but should have thrown it away and got a clean one before doing the finger stick blood sugar.<br><br>On 05/04/11 at 10:24 a.m. an interview with the Staff Development Coordinator (SDC) in charge of infection control and the Director of Nurses (DON) revealed their expectations were that nursing staff should never use a glove after dropping it on the floor. The DON stated the glove should have been discarded in the trash and not used when doing a finger stick blood sugar on Resident #14. | F 441 | | 6/1/11 |



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| F 441 | Continued From page 16<br><br>3. The facility's Infection Control Policy regarding cleaning of glucometers dated 04/25/11 read in part "each meter must be cleaned each time they are used with alcohol wipes. When using meters kept on nursing carts, they must be disinfected with disinfecting wipes since they are potentially used for multiple residents."<br><br>On 05/03/11 at 4:05 p.m. during a medication pass Licensed Nurse (LN) #2 was observed to perform a finger stick blood sugar on Resident #27. The resident had a glucometer and test strips assigned to her in a plastic bag labeled with her name, room number and were kept in a plastic file box on the wall her room. A note on the front of the file box read "clean blood glucose meter after each use with alcohol preps." LN #2 removed the glucometer from the plastic bag and placed a test strip into it. She wiped the resident's finger with an alcohol pad, stuck the resident's finger with a self-retracting lancet and placed a drop of blood onto the test strip in the glucometer. LN #2 checked the results of the blood sugar and removed the test strip from the glucometer. She put the glucometer into the plastic bag with the resident's name on it and put it back into the plastic box on the wall in the resident's room. LN #2 discarded her trash into a trash bag on her medication cart, put the used lancet into a sharps box on the medication cart and took her medication cart down the hallway to another resident's room.<br><br>On 05/03/11 at 4:54 p.m. an interview with LN #2 revealed she forgot to clean the glucometer after performing the finger stick blood sugar on Resident #27 and she was going back now to | F 441 | | 6/1/11 |



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| F 441 | Continued From page 17<br>clean it. She explained residents are assigned their own single-use glucometer and nurses have an extra one located on the crash cart for a backup. She stated facility procedure for cleaning glucometers assigned to each resident are to clean with alcohol wipes after each use. She further stated the back up glucometer on the crash cart is to be cleaned after each use with sani-wipes which contain bleach.<br><br>On 05/03/11 at 5:08 p.m. an interview with the Director of Nurses (DON) revealed it is her expectation for nurses to clean the glucometer assigned to each resident with alcohol wipes after each use. She explained there was also a glucometer on each medication cart and when that glucometer was used the nurses should clean it with sani-wipes containing bleach immediately after the finger stick procedure and let it dry for five minutes before putting it back into the medication cart. The DON stated that it was her expectation that nurses would always clean the glucometer immediately after it was used and the nurse should not have put the resident's glucometer back into the plastic bag before it was cleaned.<br><br>On 05/04/11 at 10:22 a.m. an interview with the Staff Development Coordinator (SDC) in charge of infection control in the facility and the DON revealed their expectations that a single-use glucometer that was assigned to each resident should always be cleaned by the nurse with alcohol wipes and glucometer's located on the medication carts should be cleaned with sani-wipes containing bleach.<br><br>4. Resident #9 was admitted to the facility with | F 441 | | 6/1/11 |



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| F 441 | Continued From page 18<br>diagnoses that included diabetes mellitus. Resident #9's Minimum Data Set (MDS), dated 03/21/11, revealed that she was cognitively intact and was nonambulatory. The MDS further revealed that she had one (1) stage two (2) and two (2) stage four (4) pressure ulcers. Review of Physician orders revealed that Resident #9 had orders for wound treatment to her left great toe and to the wounds on each heel. .<br><br>An observation was made on 05/03/11 at 10:50 a.m. of Licensed Nurse (LN) #3 performing a dressing change to Resident #9's bilateral heel wounds and a wound on her left great toe. LN #3 washed her hands and donned gloves. LN #3 then knelt on the floor and proceeded to remove Resident #9's stockings. She then removed the old dressing from Resident #9's left great toe, left heel and right heel. LN #3 then placed the resident's feet directly onto the floor. The open wounds on her heels were observed to be touching the floor. The wound on the top of left great toe had two areas that were black with necrotic tissue and approximately 1 centimeter in diameter. LN #3 indicated the left great toe wound had been diagnosed with Methicillin Resistant Staff Aureus. The wound on the bottom of the left heel was approximately 2 centimeters long by 1 centimeter wide. The open area was white around the edges with pink granulated tissue in the center. The wound on the right heel was approximately 2 centimeters long by 1 centimeter wide, was dark pink with granulated tissue and was located on the side edge of the heel. No drainage was noted coming from wounds. LN #3 changed her gloves and washed her hands. LN #3 cleaned the left heel wound with normal saline, Vaseline gauze applied and | F 441 | | 6/1/11 |



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| F 441 | Continued From page 19<br>wrapped with roll gauze. LN #3 then cleaned the left great toe wound with normal saline, applied antibiotic ointment with a sterile cotton swab and applied a dry dressing. The right heel wound was cleaned with normal saline, a gel ointment was applied and a dry dressing was secured with roll gauze. The wound treatments observed followed the physician's orders.<br><br>An interview was conducted on 05/03/11 at 4:25 PM with LN #3. LN #3 reported that she normally does not put anything down on the floor while changing Resident #9's dressings but that after cleaning the wounds she does not allow the wound to touch the floor again. LN #3 then reported that she should have put a barrier down prior to performing the dressing change.<br><br>An interview was conducted on 05/03/11 at 11:00 AM with the Director of Nursing (DON). The DON reported that LN #3 should have put a barrier down to protect Resident #9's feet. | F 441 | | 6/1/11 |



RJ Faddon
5/26/11