SEP 12 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to provide tracheostomy care per facility policy for 1 of 3 sampled residents (Resident # 3) whose tracheostomy care was observed and failed to perform complete respiratory assessments on 1 of 3 sampled residents (Resident # 1) with tracheotomies. Findings include: 1. Resident # 1 was admitted on 10/06/10 with cumulative diagnoses that included pneumonia, cerebrovascular accident, malnutrition, seizure disorder, hypertension, anemia, chronic encephalopathy and pulmonary embolism. The Admission Minimum Data Set (MDS) for Resident # 1 indicated her long and short term memory were impaired. Cognitive skills for daily decision making were severely impaired. The MDS indicated Resident # 1 rarely/never understood or was understood. The resident was dependent for all activities of daily living. Review of the resident's nurse's notes indicated on 04/29/11 at 8:45 AM, the resident exhibited	F 309	Compliance Alleged Date Certain for All Tags: **September 12 2011** F-309 483.25 PROVIDE CARE/SERVICS FOR HIGHEST WELL-BEING 1. Resident #3 was provided appropriate trach care and suctioning based on the policies and procedures of the facility. 8/18/11 2. Nurse #1 was provided immediate one on one training by the Staff Development Coordinator with a return demonstration to assure compliance with the policies of the facility. 8/18/11 3. 100% of residents in the facility who require respiratory treatment such as oxygen, nebulizer treatments, residents with	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Todd A Klingbeil	Administrator	9/9/11

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 309	Continued From page 1 greenish yellow nasal discharge, an increased temperature of 99.2 Fahrenheit, an increased heart rate of 113 and increased respiratory rate of 24. The resident was transferred to the hospital and admitted. The Hospital History and Physical (H & P), dated 04/29/11, indicated the resident had presented from the nursing home with difficulty breathing, fever, expectoration and unresponsiveness. The H & P further indicated the resident was transferred to the intensive care unit and was intubated. Past medical history included recurrent pneumonia. The Hospital Discharge Summary, dated 05/16/11, indicated Resident # 1 's primary diagnosis on discharge was left lower lobe pneumonia. The diagnoses list also included encephalopathy status post tracheostomy placement for respiratory failure. Discharge instructions included an order to maintain constant oropharyngeal as well as tracheal suctioning every shift and as needed. Resident # 1 returned to the facility on 05/16/11. The readmission nurse's note indicated Resident # 1 required oxygen via tracheostomy (trach), suctioning and trach care. Readmission orders included Prednisone 20 mg daily, oxygen at 28% per trach continuously (per the medical supply company conversion sheet 28% humidified oxygen was equivalent to 2 liters/per minute when given through an oxygen concentrator), suction trach every shift and as needed, change trach collar and tubing weekly and clean trach every shift with peroxide and rinse with normal saline. Resident # 1 was continued on Zosyn (an	F 309	tracheostomies, and those that require suctioning will have baseline respiratory assessments completed and documented. Any identified issues will be reported to the attending physician immediately. 9/9/11 4. 100% of licensed nursing staff will be trained on facility policies and procedures for trach care and suctioning. All licensed nurses will provide return demonstration to assure compliance and understanding of the policies. Return demonstrations will be mandatory for licensed nurses on trach care and suctioning during orientation. Continued QI audits will be completed by the Staff Development Coordinator monthly x 3 months and then quarterly to assure continued compliance. 100% of licensed nurses will be trained on complete respiratory assessments by the Staff Development Coordinator.	

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F 309	Continued From page 2 antibiotic) via intravenous route every 6 hours for 6 days. Physician ' s progress note, dated 05/23/11, indicated the visit was for a follow up after a recent hospitalization for pneumonia. The physician documented staff reported a lot of clear pulmonary secretions which the resident was able to cough up through her trach tube. Frequent suctioning was required. Noted under Physical Exam was clear lungs to auscultation and percussion throughout all fields. Under Assessment, the physician documented a cough with excessive pulmonary secretions. The plan included treating Resident # 1 with Zyrtec 10 mg daily. The care plan for Resident # 1 with a date of 05/30/11, indicated she had a potential for actual ineffective breathing pattern related to (several diagnoses listed with none marked). Goals and approaches included the resident would receive appropriate intervention if oxygen saturation level fell before (no parameter listed), will have clear and equal lung sounds and be free of peripheral edema, will be free of signs/symptoms of pulmonary edema as evidenced by normal breath sounds, heart rate and mentation, no dyspnea or peripheral edema. The 06/13/11 Physician ' s Progress Note indicated Resident # 1 ' s chest was also clear to auscultation and percussion throughout all lung fields. On 06/24/11 at 12:05 PM, Resident # 1 was noted with a low grade temperature of 99.3 degrees Fahrenheit (F). Respirations were listed	F 309	Respiratory assessment training will be completed monthly x 3 months and then quarterly to assure continued compliance with the audits to accompany the training. 9/12/11 5. Results of the return demonstration audits will be reviewed by the Director of Nursing, the Staff Development Coordinator and other Administrative Nursing Staff, completed monthly x 3 months and then quarterly thereafter to assure compliance, and will be reported to the Quarterly QA Executive Committee and audits adjusted as results dictate. 9/12/11	

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F 309	Continued From page 3 as 24 (normal range 16 to 20). Oxygen saturation was not listed. No respiratory assessment was completed to rule out a possible cause of the low grade temperature. At 11:00 PM, the nurse documented a temperature of 96 degrees F and a respiratory rate of 18. The nurse did note respirations were even and unlabored. There was no oxygen saturation listed and no indication a respiratory assessment was completed as directed by the care plan. Nurse's notes for 06/25/11 did not list an oxygen saturation or indication a respiratory assessment was completed. The note for 10:35 PM indicated Resident # 1 had been suctioned frequently with thick, clear, secretions obtained. On 06/26/11 at 2:30 AM, the nurse noted an oxygen saturation of 96% on oxygen per trach. The nurse also noted large amounts of clear mucus. There was no further oxygen saturation or respiratory assessments entered for Resident # 1 for 06/26/11. On 06/27/11 at 8:00 PM the nurse documented in the nurse's notes that Resident # 1 exhibited a congested cough. She noted also respirations were even and unlabored. There was no indication an oxygen saturation was obtained, no respiratory assessment completed or the congested cough reported. Nurse's notes for 06/28/11 did not follow up with the congested cough. Vital signs were within normal limits. No oxygen saturation was obtained nor were lung sounds auscultated. On 06/29/11 at 8:46 PM, the nurse noted	F 309		

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F 309	Continued From page 4 Resident # 1 had been suctioned 4 times. There was no description of the mucus, there was no oxygen saturation listed and no mention of a lung assessment. The nurse's note for 07/01/11 at 6:45 PM, indicated Resident # 1's respirations were even and unlabored. She was described as warm, dry and acyanotic. Vital signs were within normal limits. The nurse documented she had suctioned the resident 3 times and had obtained moderate amounts of thick, white secretions. On 07/01/11 at 10:30 AM, the nurse documented Resident # 1 had periods of apnea (periods of time with no respirations) lasting 30 seconds. Her skin was cool. When suctioned, a large amount of thick yellow mucus returned. The resident's pulse was listed as 58 (normal 60 to 80) with a respiratory rate of 22. The resident was transferred to the hospital for evaluation. Review of the medical record, dated 07/02/11, indicated Resident # 1 was transferred to the hospital and admitted for increased secretions. The Hospital History and Physical indicated Resident # 1 had been found with apenic spells. The physician also noted there was a fair amount of secretions from the tracheostomy tube. The impression was left lower lobe pneumonia. The Discharge Summary, dated 07/08/11, indicated the primary diagnosis was Pseudomonas pneumonia. Instructions included frequent tracheal suctioning. Nurse's notes, dated 07/08/11, indicated Resident # 1 had been readmitted with a tracheostomy	F 309		

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(trach). She received oxygen at 5 liters per minute via the trach, suctioning, and trach care. The admitting nurse (Nurse # 4) documented Resident # 1 had a persistent, non-productive wet cough. Sputum was described as a thick, large amount that the resident was unable to expectorate on her own. Nurse # 4 documented upon auscultation of the resident's lungs, crackles (crackles heard may indicate fluid in the lungs) were heard throughout her left side. The nurse also documented a 2 + pitting edema (edema is measured on a scale of 1 to 4 with 4 being the most severe. Pitting edema may be an indicator of uncontrolled congestive heart failure) to the resident's bilateral upper extremities and 1+ pitting edema to her bilateral lower extremities.

A Respiratory Care Evaluation, dated 07/08/11, indicated the resident had crackles on her left side. The assessment also indicated Resident # 1 had a wet, non-productive cough needing suctioning when coughing because she could not expectorate on her own. The sputum was described as large amounts of very thick, white/clear with some blood tinged.

A sheet with the title Respiratory (Pneumonia), undated indicated vital signs should be taken along with oxygen saturation. The form also indicated skin color, lung sounds, a description of sputum, presence of dyspnea, and sternal retraction should be documented.

Readmission orders, dated 07/08/11, included the continuation of Meropenem 1 gram per intravenous (IV) every 8 hours for 10 days and Tobramycin 360 milligrams IV daily for 10 days (both antibiotics) for the pneumonia. Additionally,

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the orders included oxygen at 28% humidified via trach collar continuously. The readmission orders also indicated Resident # 1 was suctioned every shift and as needed.

The Readmission Nurse ' s note, dated 07/08/11, indicated trach care had been provided. Resident # 1 had been suctioned 10 times. The nurse (Nurse # 4) documented Resident # 1 had a persistent, non-productive wet cough. The nurse added the resident was unable to expectorate sputum on her own. The sputum was described as a large amount of thick whitish clear with some blood tinged secretions. Lung sounds were described as clear on the right side and crackles (indicative of fluid in the lungs) throughout the left side. Nurse # 4 also documented Resident # 1 had 2+ pitting edema (pitting edema is measured from 0 which means no edema to 4+ which is the worse) in her upper extremities bilaterally and 1+ in her lower extremities bilaterally.

Review of the nurse's notes for the week following readmission (07/09/11 through 07/13/11) indicated the resident was suctioned from 1 to 6 times during a shift. Secretions were described as large/copious and ranged from clear/blood tinged to beige. Review of the notes did not indicate a respiratory assessment to determine if the crackles were still present had been completed on Resident # 1. There was no indication the pitting edema, present on admission had been further assessed.

A Physician's order was received on 07/11/11 for a change in the resident's Prednisone (a steroid medication used to treat inflammation including lung inflammation). The new order indicated

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F 309	Continued From page 7 Resident # 1 would receive 15 milligrams (mgs) for 3 days, then 10 mg for 3 days, followed by 5 mg for 4 days and then the medication would be discontinued. The physician also wrote orders for Robinal 1 milligram every 8 hours for excessive airway secretions. On 07/14/11 at 1:10 PM, the nurse documented Resident # 1 continued on her antibiotic. There was no documentation that indicated a respiratory assessment was completed to determine the condition of the resident ' s lungs., there was no documentation of oxygen saturation and no documentation regarding the presence of pitting edema. Charting for the 3 to 11 shift indicated the resident continued to have thick white secretions. Resident # 1 was suctioned twice. There was no indication of lung sounds or oxygen saturation documented. The nurse ' s note, dated 07/15/11 at 12:00 PM indicated respirations were unlabored. The nurse documented Resident # 1 coughed up a small amount of white secretions. Antibiotic use continued. There was no documentation of a respiratory assessment to include oxygen saturation and lung sounds as directed by Resident # 1 ' s plan of care. At 6:35 PM, the nurse documented she had suctioned the resident 6 times and received clear white secretions. There was no indication of the amount of secretions and no respiratory assessment that indicated how Resident # 1 ' s lungs sounded. The nurse's note, dated 07/16/11 at 2:15 PM, indicated Resident # 1 had been suctioned twice. The secretions were described as a copious	F 309		

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F 309	Continued From page 8 amount of yellow tinged (yellow secretions can be indicative of an unresolved infection) mucus. The resident's temperature was documented as 97.7 degrees Fahrenheit. There was no indication a respiratory assessment was completed. At 2:35 PM on 07/17/11, the nurse's note indicated Resident # 1 continued on an antibiotic. There was no indication of why the resident continued on the antibiotic, no indication documented as to whether the antibiotic relived the symptoms and no respiratory assessment or oxygen saturation as directed by the care plan. At 2:35 PM, the nurse documented the resident ' s sputum had copious amounts of thick yellow tinged. There was no respiratory assessment indicated to describe how the resident ' s lungs sounded or what her oxygen saturation measured. Review of nurse ' s notes for 07/18/11, did not indicate a respiratory assessment had been completed as Resident # 1 ' s care plan directed. There was no indication peripheral edema had been assessed. A nurse's note, dated 07/19/11 at 11:30 PM, indicated Resident # 1 had a low grade temperature of 99.1 degrees Fahrenheit. Her heart rate was listed as 101 beats per minute. There was no indication a respiratory assessment was completed. On 07/20/11 at 11:25 AM, the nurse documented the physician had been in to assess Resident # 1 due to a change in her tube feeding formula. There was no indication the physician was notified of the low grade temperature or the	F 309		

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increased heart rate. The physician ' s progress note did indicate the resident ' s lungs were clear to auscultation and percussion throughout all fields.

The nurse's note for 07/21/11 at 2:25 AM indicated the resident was suctioned "as needed". At 12:15 PM, the nurse documented Resident # 1's oxygen saturation was 92% and she had tan secretions. There was no respiratory assessment completed. At 12:20 PM, the nurse documented she was called to the room. The resident was without respirations or pulse. A Code Blue (the facility code for cardiopulmonary resuscitation) was called. The entry indicated Resident # 1 was suctioned with tan secretions retrieved. The note also indicated the resident had a large amount of tan emesis. At 12:24 PM, Emergency Medical Services arrived and transported the resident to the hospital where she later expired.

An interview was held with Nurse # 5 on 08/18/11 at 2:30 PM. Nurse # 5 worked with Resident # 1 5 days per week on the 7 to 3 shift. She was the nurse on duty when Resident # 1 was transferred to the hospital on 07/21/11. The nurse stated any resident with pneumonia or any other respiratory disease should receive a respiratory assessment that included lung sounds and an oxygen saturation. Nurse # 5 added Resident # 1 had copious amounts of secretions from her trach and occasional drooling. Normally, she would suction the resident 1 to 2 times per shift. On 07/21/11, the nurse stated she had suctioned the resident early in the shift because she could hear gurgling. The nurse added she did not listen to the resident ' s lungs. Nurse # 5 added the resident was not

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F 309	Continued From page 10 short of breath and her respiratory rate was normal, although, she did not count respirations. Nurse # 5 reviewed nurse ' s notes from 07/08/11 when Resident # 1 was readmitted to the time of her discharge. She acknowledged there had been no respiratory assessment completed for Resident # 1. Nurse # 4 was interviewed on 08/18/11 at 3:03 PM. She had been the nurse for the 07/08/11 readmission for Resident # 1. Nurse # 4 stated respiratory assessments included lung sounds, quality of the lung sounds and appearance of the trach site. Knowing how much edema a resident had was important because they affected respiratory status. Edema also made the heart work harder. The nurse added the facility policy indicated documentation was completed every shift for the duration of an antibiotic and for 24 hours after completion. Documentation included signs and symptoms for the use of the antibiotic and any side effects. Nurse # 4 reviewed the nurse ' s notes for Resident # 1 and stated there was no way to determine if the edema or crackles in the resident ' s lungs resolved. She acknowledged that after admission, nurse ' s had not addressed those issues. On 08/18/11 at 3:28 PM, an interview was held with the Quality Improvement (QI) nurse. He stated he reviewed charts for residents with wounds, allegations of abuse, and falls to make sure interventions were placed and notification completed. The QI nurse stated if a resident was admitted with pitting edema and pneumonia, he would expect to see documentation in the nurse ' s notes that described the general appearance of the resident. The note should also include lung	F 309		

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sounds, respiratory rate, skin temperature, any signs and symptoms of distress, oxygen saturation and any edema with degree of edema. The nurse added this was important since knowing how the lungs sounded would indicate if the pneumonia was resolving. Crackles, if heard, would mean fluid that would impact the resident ' s breathing. The QI nurse stated when a resident received an antibiotic the nurses were expected to chart in the nurse ' s notes every shift for the duration of the antibiotic and for 24 hours after completion. Documentation included why the resident received the antibiotic and any side effects. After review of Resident #1 ' s nurse ' s notes from 07/08/11 through her discharge, the QI nurse stated there was no respiratory assessment or assessment of her pitting edema that had been present on admission.

The Director of Nursing (DON) was interviewed on 08/18/11 at 4:04 PM. She stated a respiratory assessment should include vital signs, lung sounds, the color, consistency and amount of secretions. Documentation of antibiotics included an every shift assessment that included vital signs, the reason for the antibiotic and any side effects. After review of the nurse ' s notes for Resident # 1, the DON stated the 07/08/11 readmission note formed the baseline for follow up notes. She added that since the readmission note included crackles and pitting edema, then each nurse should have addressed those issues. The DON reviewed the notes for Resident # 1 and stated she was unable to determine if the crackles in Resident # 1 ' s lungs or the edema present on admission resolved. She stated she would have expected the nurse to notify the physician when Resident # 1 ' s sputum changed

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from white to yellow (07/16/11) and would have expected physician notification when the resident ' s vital signs deviated from her normal.

An interview was held with Resident # 1 ' s physician on 08/19/11 at 1:48 PM. He stated Resident # 1 had multiple medical conditions that made her care complex. The physician stated that a resident with recurrent pneumonia, as Resident # 1, required respiratory assessments. The physician added a respiratory assessment included information about how well the resident moved air in and out of her lungs. He stated the only way to determine air movement was through auscultation with a stethoscope. Visualization, he added could determine respiratory effort, but was not necessarily enough. Resident # 1 was unable to verbalize discomfort and problems therefore, she required more than a visual assessment. The physician stated he expected to be notified when sputum changed from clear/white to yellow. The physician added he had seen Resident # 1 the day prior to her 07/21/11 discharge and stated her lungs sounded good. He added her legs had little edema and the upper extremity edema had resolved. The physician reviewed the nurse ' s notes for Resident # 1. He stated he was not satisfied with the care and assessments she had received since the resident had repeated bouts of pneumonia. He added the lack of assessment did not alter the outcome of this resident, since he believed her sudden death had little to do with a respiratory issue.

2. According to the facility's Tracheostomy (trach) Policy, dated August 2008, under

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F 309	Continued From page 13 Procedure, Paragraph 5, the inner cannula should be removed, cleaned with hydrogen peroxide and distilled water. The facility's February 2007 policy, titled Tracheal Suctioning, the equipment included distilled water. Under Procedure, the instructions included pre -oxygenating the resident to prevent hypoxia. An Licensed Practical Nurse Orientation Skills Checklist for Nurse # 1, dated 04/07/11, was reviewed. Verification of tracheostomy skills was not listed. Resident # 3 was admitted on 06/02/11 with cumulative diagnoses of recurrent pneumonia, diabetes, tracheostomy and chronic obstructive pulmonary disease. The resident's care plan, with a problem date of 06/10/11, indicated trach care and suctioning was completed per physician's orders or facility protocol. Review of facility in-service on tracheotomies, conducted on 06/14/11 by the Staff Development Coordinator (SDC), indicated Nurse # 1 signed as attended. Under Basic Information about Tracheotomies, reviewed in the in - service, under Bullet 5, was indicated the trach should be cleaned with hydrogen peroxide, use a pipe cleaner to removed dried mucus and rinse the peroxide off the inner cannula. The 07/14/11 Significant Change in Status Minimum Data Set (MDS) coded Resident # 3 as cognitively intact and able to understand and be	F 309		

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understood. The resident was coded as requiring extensive or total assistance for all activities of daily living. Special treatments included oxygen administration, suctioning and trach care.

On 08/18/11 at 11:37 AM, an observation was made of Nurse # 1 providing trach care. The nurse washed her hands and opened the trach care kit. Two foil packages containing hydrogen peroxide were observed in the kit. The kit contained a basin with 2 compartments. Nurse # 1 opened each of the foil packets and poured 1 packet of peroxide into each basin. The nurse then removed Resident # 3's inner cannula and placed the cannula into one of the basins. She completed cleaning around the trach stoma and replaced the trach sponge. Upon completion, the nurse removed the inner cannula from the basin made sure all dried debris was removed and then placed the inner cannula into the second basin of hydrogen peroxide. Prior to replacing the inner cannula, the nurse suctioned Resident # 3. She removed the soiled gloves, washed her hands and reapplied gloves. Tap water was placed in a container. Prior to suctioning Resident # 3, the nurse lubricated the end of the suction catheter in the tap water. During the suctioning process, Nurse # 1 continued to rinse the suction catheter in the tap water. The nurse stated the kit must have been put together wrong, since the kit contained 2 packets of hydrogen peroxide and no distilled water or normal saline.

The Director of Nursing (DON) was interviewed on 08/18/11 at 1:00 PM. The DON stated the procedure for cleaning an inner cannula was to first soak the cannula in peroxide to remove debris and then rinse the cannula with distilled

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water. She added leaving peroxide residue on an inner cannula could potentially irritate the resident's airway. The DON stated when suctioning a resident, distilled water was used to lubricate the tip of the suction catheter. Tap water, she added, was not used because of the added chemicals and/or bacteria that may be present in tap water. The DON added if a resident did not have a specific order for trach care and trach suctioning, nurses were expected to follow the facility's policy and procedure when performing trach care and trach suctioning. The DON reviewed the skills check list for Nurse # 1. She stated that entry # 76 indicated policies were reviewed with the nurse, including the policy on trach care. The DON acknowledged that it was possible no other staff had actually observed Nurse # 1 perform trach care.

Nurse # 1 was interviewed on 08/18/11 at 1:16 PM. She stated no other staff member had actually validated her trach care skills by observation. Nurse # 1 stated no one had reviewed the trach care policy with her during orientation. The nurse acknowledged she had not read the facility policy and procedure on trach care and trach suctioning. Nurse # 1 stated the reason she did not rinse Resident # 3's inner cannula with distilled water was because none had been included in the trach care kit. She added she knew she should have stopped to get distilled water, but she did not. The reason she did not stop was because her kit was open and her field was set up, although, the Nurse acknowledged the field was not sterile, therefore, it could have been left unobserved while she retrieved the distilled water. Nurse # 1 stated the peroxide could irritate the lining of Resident # 3's

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F 309	Continued From page 16 trachea. The tap water could potentially cause infection. Nurse # 2 was observed performing trach care on 08/18/11 at 1:38 PM. During the procedure, the nurse was interviewed regarding the 2 foil packets in the trach care kit. Nurse # 2 stated both packets contained hydrogen peroxide. She added that was the way the trach care kits were always packaged. Nurses had to use distilled water supplied by the facility that came in large plastic jugs. The SDC stated during an interview on 08/19/11 at 9:30 AM, that she was responsible for orientation of new employees. During orientation, policies, including suctioning of a trach and trach care were reviewed. The SDC stated that all tasks listed on the skills check list had to be completed before the end of the 5 day floor orientation. After review of the check list for Nurse # 1, the SDC stated she did not realize trach care was not listed as a skill. She acknowledged that she had not personally validated Nurse # 1's skills for trach care and there was no documentation that any other staff person had validated her skills. The SDC stated on the day of surveyor observation, she had offered to review the policy and procedure with Nurse # 1. The SDC stated Nurse # 1 refused, adding she knew what she was doing and had completed trach care "a million times". The SDC verified Nurse # 1 attended the most recent in - service on trach care. She added participants were told their signature on the attendance sheet signified their understanding of the subject covered. The SDC stated that if the peroxide was left on the inner cannula, it could potentially	F 309		

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F 309	Continued From page 17 cause an infection such as pneumonia.	F 309		
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 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	Compliance Alleged Date Certain for All Tags: **September 12 2011** F-441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 1. New oxygen tubing was provided to resident #5 by the charge nurse on 8/17/11. 2. All other residents who receive oxygen therapy have been identified to determine those at risk of issues of infection control. (8/18/11) 3. 100 percent inservice of licensed nursing staff regarding the proper infection control practices for oxygen tubing, nebulizer tubing and trach supplies and tubing. New containers have been purchased to hold the reservoir	

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F 441	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to practice standard infection control policies by failing to change gloves and wash hands between handling soiled and clean linens/clothes for 1 of 2 sampled residents (Resident # 5) whose care was observed an failed to keep the open end of oxygen tubing off the floor and failed to protect a tracheostomy water collection bag from potential infection by placing the bag in a trash can for 1 of 2 sampled residents (Resident #3) whose tracheostomy care was observed. Findings include: 1. On 02/16/11, the facility's Staff Development Director (SDC) conducted an in - service on hand washing. Handouts presented by the SDC to the nurses and nursing assistants (NA) indicated hands should be washed between handling dirty and clean linens/incontinent briefs. The primary purpose was to prevent infection. Review of the Nurse Assistant Orientation Skills Checklist for NA # 1, dated 05/12/11, indicated she had been trained in infection control procedures that included proper hand washing techniques, proper handling of linen and waste disposal. An observation was made of NA # 1 providing incontinent care to the resident on 08/17/11 at 11:17 AM. The NA cleaned the stool from the resident and placed the soiled washcloth in a	F 441	bag to collect the water drippings and replace the currently used trash cans. The inservice will also include training to prohibit throwing dirty gloves in any trash can in resident rooms and reinforce the covering of unused nasal cannulas and nebulizer tubing when not in use. (complete by 8/19/11) 4. 100% of facility staff was trained regarding the changing of gloves between dirty and clean tasks to include hand washing between the removal of the dirty gloves and the application of clean gloves. Random audits of all staff of all departments will be completed by the Staff Development Coordinator weekly x 4 weeks, monthly x 3 months and then quarterly thereafter. The results of these audits will be reported to the Director of Nursing, training provided as necessary and reported to the monthly QA	

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F 441	Continued From page 19 plastic bag. The soiled incontinent brief was also placed in a separate plastic bag. After disposing of the soiled items, and without changing gloves or washing her hands, the NA placed a clean incontinent brief on the resident and dressed the resident in her clothes for the day. The NA then removed her gloves, but did not wash her hands. The plastic bags with the soiled items were removed from the room. The Director of Nursing (DON) was interviewed on 08/18/11 at 8:45 AM. She stated her expectation was for all staff to change gloves and wash hands between handling dirty and clean linens/briefs/clothes. During an interview with NA # 1 on 08/18/11 at 9:45 AM, she stated she had been taught to change gloves and wash her hands between handling dirty and clean linen. The NA acknowledged she had not changed her gloves or washed her hands between removing and disposing of the soiled brief and clothes and applying a clean brief and the resident's clothes. NA # 1 stated she did not know why she had not changed gloves or washed her hands. The SDC was interviewed on 08/19/11 at 9:30 AM. She stated she was responsible for orientation of new employees. Orientation included basic infection control and when staff should change gloves and wash their hands. The SDC stated the potential danger of NA # 1 not changing gloves and washing hands between handling soiled briefs/linens/clothes and handling clean items would be the spread of infection. She added that while bacteria may not be visible, it could be present and transferred to the resident.	F 441	committee. Further audits will be adjusted based on demonstrated needs. (completed by 9/12/11) 5. Audits will be completed daily on Administrative rounds to be turned in to the Director of Nursing or designee for review. The Director of Nursing or designee will review the audits and perform random audits weekly for 4 weeks, then monthly for 3 months and then quarterly as needed. The results of the audits will be reported to the monthly QI committee and adjustments to the training and audits made as necessary. Audit results will be reported to the quarterly Executive QA committee and other adjustments made to the audits and training as necessary. (9/12/11)	

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F 441	Continued From page 20 2. Resident # 5 was most recently readmitted on 07/18/11. The Transfer/Discharge Summary listed the resident's discharge diagnoses as acute respiratory failure and aspiration pneumonia. On 08/17/11 at 11:17 an observation was made of Resident # 5's oxygen tubing. One end of the tubing was connected to her tracheostomy (trach) and the other end was laying in the floor. The water collection bag for the trach was laying in the trash can. Trash was also present in the trashcan. While giving care to Resident # 5, the Nursing Assistant (NA) # 1 moved the bed which caused the oxygen tubing to make a sweeping motion across the floor approximately 12 inches to 18 inches in length. At 11:30 AM, the NA completed her tasks, removed the trash bag from the trash can and replaced it with a clean bag. She took the plastic bags with the soiled brief and the trash and prepared to leave the room. The NA stated the water collection bag normally stayed in the trash can. When prompted, she acknowledged the tubing on the floor and stated the end laying on the floor was usually connected to the machine (pointed to the oxygen concentrator). NA # 1 picked the oxygen tubing up from the floor and placed the tubing on the resident's bed. NA #1 stated she would notify the nurse responsible for Resident # 5's care that day. At 11:33 AM, Nurse # 3 entered the room. She picked the oxygen tubing off the bed and walked toward the oxygen concentrator. As the tubing was almost touching the connector to the oxygen concentrator, Nurse # 3 was stopped. NA # 1 entered the room and stated she had told Nurse # 3 the oxygen tubing had been on the floor. The nurse stated she had been nervous	F 441		

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F 441	Continued From page 21 and left the room to retrieve new tubing. The nurse returned at 11:41 AM and applied the new oxygen tubing. An interview was held with the Director of Nursing (DON) on 08/18/11 at 8:45 AM. She stated it was usual and customary for the water collection bag to be placed in a dedicated trash can because of potential leakage. She stated the expectation was for the trash can to be used only for the water collection bag and trash was not to be present. The DON stated since there was an opening large enough for water to seep out of the bag, it was possible for bacteria to enter the bag and ultimately the trach tubing which could cause infection. She stated the expectation would have been for Nurse # 3 to have taken the oxygen tubing to the room when she was told the oxygen tubing had been on the floor. The DON stated the nurse should not have to have been prompted to get new tubing. NA # 1 was interviewed on 08/18/11 at 9:45 AM. She stated until prompted she was unaware the oxygen tubing had been on the floor. NA # 1 stated she had told Nurse # 3 the oxygen tubing had been on the floor. The NA stated that normally residents with trachs have 2 trash cans in the room. One trash can was used for trash and one trash can was used to hold the water collection bag. She added Resident # 5 only had the one trash can present. The NA added in addition to the water collection bag, the trash can also contained trash. Nurse # 3 was interviewed on 08/19/11 at 10:56 AM. She stated the facility policy indicated oxygen tubing was to be changed weekly and as	F 441		

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F 441	Continued From page 22 needed. The facility policy also indicated trash was not to be put in the trash can that held the water collection bag for trachs. She stated trash had been in the trash can early Tuesday morning (08/17/11) but she had not stopped to empty the trashcan. Nurse # 3 stated if water could come out of the bag, then bacteria could get in the trach tubing causing infection. The nurse added NA # 1 had told her the oxygen tubing had been on the floor. She stated she did not take new tubing to the room because she wanted to see the tubing before replacing. Nurse # 3 stated she just was not thinking when she started to hook up the oxygen tubing that had been on the floor back to the oxygen concentrator.	F 441		