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
	345306	A. BUILDING ______ B. WING ______	09/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DR - PO BOX 1828 STATESVILLE, NC 28677

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	After meeting with the surveyor and learning of the deficient practice, Director of Nursing (DON) immediately met with the charge nurse and RN that cared for Resident #1. They were educated and verbalized an understanding of the correct process to report injuries of unknown cause immediately to the DON or designee. Knowing that all residents are potentially affected by this deficient practice, all nursing staff have been educated on definition of injury and more specifically, of unknown origin. The nursing staff have been educated on the abuse policy, which clearly states injuries must be reported to the DON or designated Nursing Supervisor, so that a complete investigation and report can be completed. Staff was required to review the abuse policy and information on injuries of unknown origin. A sign-in sheet was required for proof of education. The abuse policy is currently a part of the annual competency requirement. New employees are required to review the abuse policy and injury information sheet during orientation. For quality monitoring, the DON will do 20 random resident rounds per month. These residents will be asked and / or evaluated to determine if any injuries and / or accidents have occurred. If any have occurred, the DON or designee will ensure reporting and investigation have been completed per policy and appropriate follow-up with employee(s). This data will be shared at staff meetings each month and to Quality Coordinating Council (QCC) quarterly. If	9/23/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Connie Coker RN	DON	10-14-11

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.

original signature 9-23-11 mh

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OCT 14 2011
BY: MH

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to report a fractured thumb of unknown origin to the state as required for one (1) of two (2) sampled residents. (Resident #1) The findings are: The facility's Abuse Prohibition Policy reviewed in March 2010 included any suspicious bruising or injuries that may indicate abuse are investigated. The policy also included that the state agency would be notified as appropriate. Resident #1 was admitted to the facility on 3/5/10. The Minimum Data Set (MDS), an annual dated 3/5/11, coded him with long and short term memory impairments, having verbal abusive behaviors, and requiring extensive to total assistance with most activities of daily living skills except for eating. He was also coded as being nonambulatory. Nursing notes dated 5/8/11 at 11:45 a.m. revealed that his private sitter reported the resident's left thumb was swollen and bruised. Per the nursing note, he was able to move it and the skin was intact. Nursing notes dated 5/8/11 at 11:50 a.m. revealed the charge nurse was informed of the condition of Resident #1's left thumb and "unknown cause." Nursing notes dated 5/10/11 at 10:45 a.m. noted Resident #1 complained of discomfort to his left thumb, was guarding his thumb area and left hand. The note described the left thumb as	F 225	100% reporting / investigation is not met, education and counseling will be held for responsible staff. If no unreported occurrences are found after 3 months, the audit will go to an annual audit.	

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F 225	Continued From page 2 bluish green in color. The resident was able to move it. The note stated "cause unknown." The physician was notified. A Xray report of Resident #1's left thumb dated 5/10/11 revealed three views of the left thumb showed a nondisplaced fracture of the base of the proximal phalanx of the first finger. Review of abuse investigations and incident reports revealed nothing was reported to the state regarding Resident #1's fractured thumb. Interview with the Director of Nursing (DON) on 9/1/11 at 8:40 AM confirmed that no report of Resident #1's fractured thumb, which was an injury of unknown origin, was reported to the state as required. She revealed that the nurses did not suspect abuse because he was sometimes combative with care that they did not complete an incident report. The DON stated that if an incident report was completed, she would have completed an investigation and submitted the required reports to the state. She was unaware of this injury.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to investigate an injury of unknown	F 226	The DON immediately met with the charge nurse and RN for Resident #1. They were immediately educated on the facilities policy of reporting injuries of unknown origin so that a complete investigation can be conducted. Each staff member involved in this deficient practice verbalized that reporting of injuries and / or accidents are reported to the Charge Nurse immediately and placed in the Midas computer incident system. All other staff were immediately	9/23/11

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F 226	Continued From page 3 origin, a fractured thumb, for one (1) of two (2) sampled residents. (Resident #1). The findings are: The facility's Abuse Prohibition Policy, reviewed March 2010, included any suspicious bruising or injuries that may indicate abuse are investigated by the Nurse Manager and Director of Nursing (DON). The policy continued stating that part of the investigation would be to analyze the situation to determine what could be done to prevent future occurrences. Per the facility's Incident Reporting and Investigative Procedure revised October 2009, all unusual incidents are to be documented and reported via the computer system and specified personnel was to be informed for necessary follow up. An incident was described as any event that is not consistent with the normal or expected outcome. Resident #1 was admitted to the facility on 3/5/10. The Minimum Data Set (MDS), an annual dated 3/5/11, coded him with long and short term memory impairments, having verbal abusive behaviors, and requiring extensive to total assistance with most activities of daily living skills except for eating. He was also coded as being nonambulatory. Nursing notes dated 5/8/11 at 11:45 a.m. revealed that his private sitter reported and showed the resident's left thumb was swollen and bruised. He was able to move it and the skin was intact. Nursing notes dated 5/8/11 at 11:50 a.m. revealed the charge nurse was informed of the	F 226	educated during the time of the survey on September 1, 2011 that injuries are to be reported immediately to the DON or designated Nursing Supervisor. Knowing that all residents are potentially affected by this deficient practice, a new 24 hour reporting sheet has been developed for use for the nursing staff. This reporting sheet has space for team leaders to document any accidents and injuries that have occurred on their shift. This sheet will be kept at the nursing station and the DON will receive a copy for review to ensure all injuries and incidents are investigated thoroughly. Staff were required to review the abuse policy and educated on the definition of injuries of unknown origin. A sign-in sheet was required for proof of education with a completion date of September 23, 2011. This policy and definition is also reviewed annually at mandatory competency days. A reporting policy for accidents and injuries and abuse policy are currently in place and meet state standards. For quality measuring, the DON will conduct 20 random resident rounds per month. These residents will be asked and/or evaluated to determine if any injuries and/or accidents have occurred If any have occurred, the DON will ensure reporting and an investigation have been completed. This data will be shared at monthly staff meetings and quarterly to the QCC for a goal of 100% reporting of all accident/ injuries. If 100% reporting is not met, education and counseling will be	

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F 226	Continued From page 4 condition of Resident #1's left thumb and "unknown cause." Nursing notes dated 5/10/11 at 10:45 a.m. noted Resident #1 complained of discomfort to his left thumb, was guarding his thumb area and left hand. The note described the left thumb as bluish green in color. The resident was able to move it. The note stated "cause unknown." The physician was notified. A Xray report of Resident #1's left thumb dated 5/10/11 revealed three views of the left thumb showed a nondisplaced fracture of the base of the proximal phalanx of the first finger. Review of abuse investigations and incident reports revealed nothing was written other than what was in the above nursing notes related to Resident #1's fractured thumb. The nursing notes did not include any documentation of combative behaviors on or around the dates of injury. A phone interview was conducted on 9/8/31/11 at 12:14 p.m. with licensed nurse (LN) #4 who documented the first observation of injury on 5/8/11. LN #4 stated that Resident #1 was observed with a swollen thumb on Sunday 5/8/11. LN #4 stated that a private sitter had given him a shower on Saturday and reported nothing unusual. Another sitter with Resident #1 on Sunday reported the swollen thumb. LN #4 stated she asked the Sunday sitter about it and she did not know how it occurred. She related that she followed up and asked the Saturday sitter who also knew nothing about the bruised thumb. LN #4 stated she spoke to the nurse aide who worked the night shift between Saturday and Sunday who reported no knowledge of the injury.	F 226	held for responsible staff. If no unreported events are found for 3 months the audit will go to annual.	

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F 226	Continued From page 5 LN #4 stated she reported it to the weekend charge nurse for follow up. She further stated that her only documentation of the injury and incident was in the nursing notes. She did not fill out an incident report or document her conversations with the sitters or staff but passed the information onto the oncoming shift. Interview with the DON on 9/1/11 at 8:40 a.m. revealed that if an incident report had been completed, then she would have known about the injury and investigated it. Interview with the weekend charge nurse (LN #3) on 9/1/11 at 8:45 a.m. revealed she received a report about the thumb from LN #4. LN #3 did not observe the injury first hand but the physician was notified. She stated she did not suspect abuse as he had ongoing combative behaviors that were normal for him and a past history of carpal tunnel. She thought the swelling may have been a reoccurrence of carpal tunnel. A Xray was gotten a few days later that showed a fracture. She could not recall if an incident report was completed.	F 226		
F 279 SS=C	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	Residents that were affected by this deficient practice (Residents #1, #4, #6 and #7) had revisions made to their care plans. These revisions included the measurable goals, interventions and timeframes. The MDS Nurse was re-educated during state survey on correct development of the comprehensive care plan. Since all residents are potentially affected by this deficient practice, the care plan process was immediately	9/23/11

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F 279	Continued From page 6 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to develop care plans for four of four sampled residents which included measurable goals and or complete interventions. (Residents #1, #4, #6, and #7). The findings are: 1. Resident #1 was admitted to the facility on 3/5/10. The Minimum Data Set (MDS), an annual dated 3/5/11, coded him with long and short term memory impairments and requiring extensive to total assistance with most activities of daily living skills (ADLs) except for eating. He was coded as utilizing an indwelling urinary catheter, having verbal behaviors, rejection of care and using psychotropic medications. He was also coded as being nonambulatory. Review of the Care Area Assessments (CAAs) dated 3/5/11 revealed care plans would be developed for the areas of ADLs, catheter use, behaviors and psychotropic medication use.	F 279	revised. The MDS Nurse began using a notebook which provides specific examples of measurable objectives, goals, interventions, and time frames. The MDS nurse is using this a guide to develop the Comprehensive Care Plan. A new care planning document has been created and will be utilized once approved by the Medical Director. This new document will ensure all care planning components are being met. A new care plan meeting time has been incorporated effective immediately beginning September 22, 2011 of 9 am – 12 noon every Tuesday. For quality measuring, the DON will audit 30 care plans per month for 3 months with a goal of 100% care plan development and completeness. If 100% compliance is met at the end of 3 months, then audits will be 30 care plans annually. This data will be shared at monthly staff meetings and quarterly to the QCC.	

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F 279	Continued From page 7 Care plans were developed on 3/8/11 which did not have measurable goals or interventions to ensure the goals were achieved as follows: *The ADL care plan identified the problem was having decreased ADLs and decreased mobility. There was no goal only a statement that Resident #1 required total care with ADLs but did feed himself. There were no interventions. *The Catheter use care plan stated the catheter was due to an inability to void. There was no goal and the only intervention was to continue with physician orders. *The Behavior care plan noted the problem was the resident continued to have agitation with staff and sitters. There was no goal and the only intervention was to use a calm approach when talking with him. *The Psychotropic medication care plan stated the medication of Seroquel and amount ordered and that the physician wrote an order for nursing to try to get the resident to take this medication as ordered. Interview with the Minimum Data Set (MDS) Coordinator on 8/31/11 at 5:25 p.m. revealed she had specific goals for each of the above areas in her mind but did not document them. She stated examples i.e. would maintain Resident #1's ADLs, would ultimately have Resident #1's urinary catheter removed, Resident #1 would have fewer outbursts and behaviors, etc. The MDS coordinator confirmed that the goals and interventions were not complete and detailed to give a reader an accurate view of the goals and interventions to use for Resident #1. On 9/1/11 at 11:25 a.m. the Director of Nursing stated the care plans do not have complete goals	F 279		

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F 279	Continued From page 8 and interventions as they were written. She further stated that this past Monday, she discussed a need for care plan improvement with the nursing consultant. 2. Resident #6 was admitted to the facility in 2011 with diagnoses including a left hip fracture, osteoporosis and dementia. An admission minimum data set (MDS), dated 8/22/11 assessed Resident #6 with a fall prior to admission, requiring extensive staff assistance with transfers, bed mobility, ambulation, dressing, and toileting. Resident #6 was also assessed as requiring limited staff assistance with bathing/hygiene and impaired range of motion in her lower extremities. Her balance was assessed as independent moving from a seated to standing position and moving on and off the toilet and unsteady with walking, turning around while walking and surface-to-surface transfer. The 8/22/11 Care Area Assessment (CAA) summary revealed Resident #6 was at risk for problems with falls, nutritional status, and activities of daily living (ADLs)/mobility and that these areas would be addressed in her plan of care. The goals for the active plan of care, dated 8/23/11, related to falls recorded that Resident #6 would have no signs or symptoms due to risk of falls with a recent fall at home and history of dementia. The plan of care did not identify a specific time frame related to this goal. Additionally, the plan of care did not identify interventions related to ADLs/mobility. On 9/1/11 at 1:30 PM, in an interview with the MDS Coordinator, she reviewed the Resident's CAA summary and plan of care and stated that	F 279		

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F 279	Continued From page 9 the plan of care should include measurable goals with interventions. She confirmed that the plan of care for Resident #6 did not include the specific time frame for the goal related to falls and did not include interventions for ADLs/mobility. On 9/1/11 at 2:30 PM, in an interview with the Director of Nursing, she confirmed that she completed the plan of care for Resident #6. She reviewed the plan of care and confirmed that the goal related to falls did not include a specific time frame and that the interventions could have been more comprehensive. She further stated that she had identified the need to develop care plans further, but a plan for further development had not been completed or implemented. 3. Resident #7 was admitted to the facility in 2011 with diagnoses including chronic pain (back), weakness, psychosis, osteoporosis and bilateral knee replacement. The admission minimum data set (MDS) dated 6/27/11 assessed Resident #7 as having mood changes to include depression, difficulty sleeping, decreased energy and poor appetite. Resident #7 required limited assistance with transfers, dressing, toileting and ambulation and extensive assistance with bathing/grooming. Resident #7 was also assessed with impaired range of motion of her upper extremities and unsteady balance. The 6/28/11 Care Area Assessment (CAA) summary revealed Resident #7 was at risk for problems with falls, incontinence, psychological well-being/mood, and chronic pain and these problems would be addressed in her plan of care. The plan of care did not identify specific time frames related to the goals for each problem and	F 279		

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F 279	Continued From page 10 the problem of chronic pain was not addressed with measurable goals or interventions in the plan of care. On 9/1/11 at 1:30 PM, in an interview with the MDS Coordinator, she reviewed the Resident's CAA summary and plan of care and stated that the plan of care should include measurable goals with interventions. She confirmed that the plan of care for Resident #7 did not include specific time frame for each goal and that the concern with chronic pain was not addressed in the plan of care. On 9/1/11 at 2:30 PM, in an interview with the Director of Nursing, she confirmed that she completed the plan of care for Resident #7. She reviewed the plan of care and confirmed that the goals did not include specific time frames and chronic pain had not been addressed in the plan of care. She stated that the Resident's plan of care could have been more comprehensive. She further stated that she had identified the need to develop care plans further, but a plan for development had not been completed or implemented. 4. Resident #4 was admitted to the facility with diagnoses including Peripheral Vascular Disease (PVD), Diabetes Mellitus with foot ulcers, Neuropathy, and Renal Insufficiency. On the 06/22/11 admission Minimum Data Set (MDS) Resident #4 was assessed as requiring limited assistance with bed mobility and transfers, walking, dressing, toileting and personal hygiene. Resident #4's balance was assessed as being not steady when moving from seated to standing position, walking with assistive devices, turning	F 279		

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F 279	Continued From page 11 around, moving on and off toilet, or with surface to surface transfers. The 06/23/11 Care Area Assessment (CAA) Summary revealed Resident #4 was at risk for problems with Activities of Daily Living (ADLs) and indicated the area would be addressed in the residents care plan. Resident #4's active care plan, dated 06/28/11, revealed no reference to ADL management and provided no goals and/or interventions. During an interview on 8/31/11 at 3:40 p.m., the MDS Coordinator reviewed the care plan for Resident #4 and confirmed ADLs was not addressed and no goals or interventions were documented. The MDS Coordinator stated she should have addressed ADLs on the care plan for Resident #4. During an interview on 8/31/11 at 5:15 p.m., the Director of Nursing (DON) stated Resident #4's care plan should have addressed the area of ADLs and included goals and interventions.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and physician and staff interviews the facility failed to follow a physician's order to complete a laboratory test for one (1) of eight (8) sampled residents. (Resident #4).	F 281	The physician for resident #4 was immediately notified of the omission and no new orders were received for Resident #4. An incident report was immediately completed in the Midas computer system regarding this lab omission and a complete investigation was conducted to determine the cause. Resident #4's medical record was reviewed to ensure that no other omissions were present. Knowing that all residents are potentially affected by this	9/23/11

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F 281	Continued From page 12 The findings are: Resident #4 was admitted to the facility with diagnoses including Peripheral Vascular Disease (PVD) and Diabetes Mellitus with foot ulcers. Resident #4's medical record revealed a physician's order, dated 7/29/11, for a Partial Thromboplastin Time (PTT) laboratory test, used to determine bleeding or clotting disorders. Review of laboratory test results in the medical record and the computerized laboratory test history for Resident #4 revealed the PTT, ordered 7/29/11, was not completed. During an interview on 9/01/11 at 1:30 PM, the Director of Nursing (DON) revealed Licensed Nursing (LN) staff were responsible for ordering and ensuring that laboratory tests were completed as ordered by the physician. The DON stated, when LN staff note/sign an order for a laboratory test they indicated they arranged for the laboratory test and the order was completed. The DON stated LN #1 should have entered the PTT laboratory test in the computer to ensure that laboratory staff completed the PTT. The DON stated every twenty four (24) hours all physician's orders were reviewed by a nurse and signed off that all orders were processed. The DON reviewed Resident #4's orders and confirmed the nurse completing the 24 hour review did not catch the oversight. During an interview on 09/11/11 at 2:30 PM the physician who ordered the 07/29/11 PTT stated he could not recall if he was aware the PTT was not completed. The physician stated he was	F 281	Deficient practice, a double check will be performed when any nurse takes a verbal or telephone order. Another nurse will be required to co-sign and verify that these orders have been processed correctly. Chart audits will be performed on 20 residents per month to ensure that 100% of all labs audited have been performed. Audits will continue until compliance is 100% for 3 months. This data will be shared at monthly staff meetings and quarterly to the QCC. If any labs / tests are not performed as ordered, a complete investigation will be performed and counseling / education will be provided to responsible staff.	

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F 281	Continued From page 13 monitoring other labs as well as the PTT and he would have reordered the PTT had it been an essential laboratory test. The physician stated the lab was for information regarding the cause of bleeding from a wound and treatment changes were not pending upon the lab results. During an interview 09/01/11 at 2:40 PM LN #1, responsible for noting/signing the 07/29/11 physician's order, stated when noting the physician's order the PTT laboratory test was overlooked and did not get ordered.	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to rinse a body wash product from the skin of one (1) of two (2) sampled residents observed for the provision of incontinence care. (Resident #1) The findings are: Review of the manufacturer's instructions located on the back label of a body wash product indicated, squeeze out, lather on, and rinse. Resident #1 was admitted to the facility on 3/5/10. The Minimum Data Sets (MDS), an annual dated	F 312	The nurse aid immediately rinsed off the body wash product from Resident #1 during observation by the surveyor. Nursing staff was made aware so that skin assessments could be done to check for any signs of skin irritation. All staff caring for this resident were immediately educated and information regarding the home product was immediately added to the Kardex. Currently, our facility uses a no-rinse agent for cleansing. Knowing that all residents are potentially affected by this deficient practice, the DON immediately held staff huddles to educate staff. A mandatory staff meeting was also held on 9/28/11. The staff were educated that any time an outside product is brought in for resident use, the team leader will be notified immediately. The team leader will write the name of the product on the Kardex and how it is to be used per the manufacturer's guidelines. For quality	9/23/11

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F 312	Continued From page 14 3/5/11 and a quarterly dated 6/8/11, coded him with long and short term memory impairments and requiring extensive assistance with most activities of daily living skills including toileting, hygiene and bathing. He was coded as having bowel incontinence and having an indwelling urinary catheter. On 08/31/11 at 8:30 a.m. Nursing Aide (NA) #1 was observed providing incontinence care to Resident #1. Observations of Resident #1's perineal area and buttocks revealed reddened intact skin. During the observation, NA #1 prepared a basin with water and a body wash product and cleansed the resident's perineal area and buttocks. Without rinsing the body wash from the resident's skin, NA #1 dried the resident with a towel and placed a clean brief on Resident #1. An interview with NA #1 on 08/31/11 at 8:40 a.m. was conducted. When asked what type of cleanser she used to wash Resident #1, she picked up the product and stated "this is what the family provided." After reading the instructions for use on the product label, NA #1 indicated she did not realize the product needed rinsing. An interview with the Director of Nursing (DON) on 09/01/11 at 9:00 a.m. revealed she expected the NA to rinse the body wash from the resident's skin prior to drying the skin and placing a clean brief.	F 312	monitoring, random audits will be performed on 20 residents per month to ensure any outside products have been identified and are written on resident's Kardex. Audits will continue for 3 months or until 100% compliance is met. This data shall be shared with staff at monthly staff meetings and quarterly to the QCC. If 100% compliance is not met, counseling and re-education will occur with responsible staff.	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371	During inspection, dust and grease were noted on storage racks and on sprinkler system heads. All storage racks mentioned in report were immediately	9/23/11

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F 371	Continued From page 15 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility record review, the facility failed to maintain clean storage units. One of one pot storage racks and two of five storage carts used to store stainless steel pans and plastic storage containers were observed with a dusty, greasy film. The findings are: On 8/30/11 an observation of the kitchen from 11:02 AM to 11:40 AM revealed the following concerns with storage units. a. On 8/30/11 at 11:20 AM, a pot storage unit was observed secured to a cook's prep table. The storage unit was full of metal pots which were suspended from hooks secured to the storage unit. Additionally, cooking utensils were hung directly from the storage unit. The storage unit was observed with a thick layer of dust which hung from the top of the storage unit and from the hooks. An additional observation on 9/1/11 at 10:44 AM revealed the storage unit was in the same condition as previously described. b. On 8/30/11 at 11:21 AM, a five-shelf storage unit was observed adjacent to the cook's prep table/pot storage unit with each shelf full of	F 371	cleaned. The sprinkler system was also cleaned immediately. An additional cleaning will be added to the storage areas in the kitchen. This will be in addition to twice yearly cleanings in March and October. The sprinkler system will be vacuumed 2 times a year. A food service cleaning list has been developed and the Food Service Director will monitor and initial form for completeness three times a year. If any dust or build-up is noticed during inspection, an additional cleaning will be scheduled immediately. For quality monitoring, the storage areas and sprinkler system heads will be inspected monthly by the Food Service Director. If any dust or buildup is noticed during monthly inspection, an additional cleaning will be scheduled immediately. Findings of the quality monitoring will be reported to the staff at monthly staff meetings and quarterly to the QCC.	

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F 371	Continued From page 16 stainless steel pans stored directly on each of the shelves. Each shelf was observed with a build-up of a greasy residue and dust hanging from this residue. An additional observation on 9/1/11 at 10:44 AM revealed the storage unit was in the same condition as previously described. c. On 8/30/11 at 11:23 AM, the kitchen's sprinkler system was observed suspended from the ceiling and ran the perimeter of the kitchen, crossing food prep areas. A collection of dust was observed and hung from the sprinkler pipes and concentrated on each of the sprinkler heads. An additional observation on 9/1/11 at 10:49 AM revealed the sprinkler system was in the same condition as previously described. An interview on 9/1/11 at 10:45 AM with the dietary staff #1 revealed that he routinely stored clean pots and pans on the storage units from the dish machine area. He stated he had not noticed that the storage units had a collection of dust and a greasy residue. He observed the storage units and confirmed they needed to be cleaned. An interview and observation of the storage units on 9/1/11 at 10:49 AM with the food service director revealed that the storage units for pots, pans and plastic containers were cleaned twice yearly, March and October. He stated during the observation that he would instruct staff to include more routine cleaning of these storage units. He also observed the sprinkler system and stated that it was last cleaned June 2011, but staff probably did not clean the sprinkler heads because they may have been afraid of setting off the system. He further stated that he would help staff develop a way to clean the sprinkler heads without setting off the system.	F 371		

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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	After being notified by the surveyor of the deficient practice, the DON met with LN #2. Education regarding proper hand washing hygiene was provided and LN #2 verbalized a complete understanding of the hand washing policy. For Resident#3, a note was added to the Kardex reminding staff to perform hand hygiene after any glove removal during the resident's wound care and treatment. Knowing that all residents are potentially affected by this deficient practice, all staff were immediately educated on the current hand washing policy, which includes hand hygiene anytime gloves are removed. All staff have been required to review the policy and document on a provided sign-in sheet. This policy also is an annual competency and provided at new employee orientation. The Infection Control Nurse provided an inservice at a mandatory staff meeting on September 28, 2011. This inservice included proper hand washing techniques with a focus on washing hands between glove removal and reapplication, and review of current policy and impact on patient safety. For quarterly monitoring, audits of 20 per month will be analyzed by the DON and reported at the Infection Control Meeting, and Safety Committee each quarter. This data will also be shared at monthly staff meetings and quarterly to the QCC.	9/28/11

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F 441	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observations, policy review and staff interviews, the facility failed to clean their hands when changing gloves during wound care for one (1) of three (3) residents. (Resident #3) The findings are: Review of the facility's "Hand Hygiene" policy dated 05/2003 indicated decontaminate hands after contact with body fluids or excretions, non-intact skin, and wound dressings if hands are not visibly soiled. Decontaminate hands before donning gloves and after removing gloves. Resident #3 was admitted to the facility on 08/18/11 with diagnoses including cellulitis, chronic lymphedema of bilateral lower extremities, and diabetic neuropathy. Review of Resident #3's medical record revealed placement of a Peripherally Inserted Central Catheter (PICC) and was receiving Intravenous (IV) antibiotics for treatment of cellulitis of both legs. Physician orders dated 08/18/11 indicated apply Silver Sulfadiazine 1% to bilateral calf wounds daily. Physician orders dated 08/23/11 indicated apply Santyl (a topical debridement ointment) to wounds with necrotic tissue daily, right heel, right medial ankle and right fifth toe. On 08/31/11 at 11:30 AM Licensed Nurse (LN) #2 was observed providing dressing change and wound care for Resident #3. LN #2 sanitized her	F 441		

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

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F 441	Continued From page 19 hands and applied gown and gloves and removed the dressing from Resident #3's left leg. LN #2 removed her gloves and donned clean gloves without sanitizing her hands. LN #2 cleansed the left lower leg with a wound cleanser and wiped the cleanser off with gauze pads. Resident #3's leg was observed to have fluid filled raised areas with serous drainage noted coming from some of the raised areas. LN #2 cleaned the left heel wound, applied a dressing. Wearing the same gloves, LN #2 removed the old gauze dressing from Resident #3's right leg, removed the soiled gloves and donned new gloves without sanitizing her hands. LN #2 proceeded to cleanse, dry, apply cream and dress the right leg. During an interview on 08/31/11 at 12:25 PM, LN #2 stated it was not a sterile dressing change and did not feel she needed to utilize hand hygiene between glove changes. On 09/01/11 at 9:00 AM the Director of Nursing (DON) was interviewed and revealed she would expect the nurse to sanitize hands between glove changes while performing dressing changes.	F 441		