| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345281 | A. BUILDING _____ B. WING _____ | C 08/22/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **STANLY MANOR** | **625 BETHANY CHURCH ROAD BOX 38 ALBEMARLE, NC 28001** |

| (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 |
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| F 157 SS=D | 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>(g)(14) Notification of Changes.<br><br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br><br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br><br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br><br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br><br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br><br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br><br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br><br>(A) A change in room or roommate assignment | F 157 | | 9/19/17 |

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

Electronically Signed | 09/13/2017

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|---|---|---|---|---|
| F 157 | Continued From page 1<br>as specified in §483.10(e)(6); or<br><br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br><br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, and staff interviews the facility failed to inform the resident ' s physician of her three-day tube feed leak which resulted in the risk for loss of nutrition and hydration for one of two residents reviewed (Resident #1).<br><br>Findings included:<br>Resident #1 was first admitted to the facility on 1/16/17 and admitted to Hospice 4/12/17.<br><br>The quarterly Minimum Data Set dated 7/11/17 revealed Resident #1 had severely impaired cognition. The resident required total assistance for activities of daily living and required one staff for feeding. The resident had a feeding tube and was on a physician ' s prescribed weight gain regimen. The resident ' s diagnoses were Alzheimer ' s disease, dementia without behaviors, adult failure to thrive, and dysphagia.<br><br>Resident #1 ' s care plan dated 8/2/17 revealed goals and interventions for her gastrostomy tube and tube feedings and at risk for dehydration and malnutrition.<br><br>Resident #1 had a physician ' s order dated 8/2/17 to keep the head of the bed (HOB) | F 157 | Preparation and or/execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged on conclusions set forth in this 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>On 8/21/2017 at approximately 2:30pm RN replaced port cap on gastrostomy tube to stop leakage and ensure proper functioning of tube.<br><br>All licensed teammates (RN's/LPN's) will receive education on management of gastrostomy tube ports by September 19, 2017 . All licensed teammates (RN's/LPN's) were educated on notification of changes to the resident; consult with residents physician and notify consistent with his or her authority, the resident representative(s) when there is a change.<br><br>The Director of Nursing, Assistant Director of Nursing or Staff Development | |

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| F 157 | Continued From page 2<br>elevated during tube feeding.<br>A physician ' s order dated 8/9/17 revealed Osmolite 1.5 at 40 milliliters per hour (liquid nutritional supplement) through the gastrostomy tube.<br><br>On 8/21/17 at 11:40 am Resident #1 was lying in her bed with the HOB elevated and her gastrostomy tube feeding infusing at 40 milliliters per hour. The tube feeding was leaking from the tube port cap (extra port in addition to the tube feeding port placed at the hospital 8/2/17) into the bed on to the pillow, sheets, mattress, resident ' s clothing, and the resident was sitting in a puddle of tube feeding.<br><br>On 8/21/17 at 12:45 pm Resident #1 was in her bed and the tube feeding was leaking at the tube port cap.<br><br>On 8/21/17 at 1:20 pm Nurse # 4 (Charge Nurse) was informed by the surveyor of Resident #1 ' s leaking tube feeding.<br><br>On 8/21/17 at 1:30 pm Nurse #1 (assigned to the resident) and Nurse #4 entered Resident #1 ' s room to evaluate the leaking tube feeding. The resident was lying in her bed with the head of the bed elevated. Her tube feeding was infusing into the gastrostomy tube at 40 milliliters per hour and into the bed and onto the resident from the extra port. Nurse #1 replaced the same type of cap to the extra port (only cap available).<br><br>On 8/21/17 at 1:45 pm an observation was done of clothes and linen change for Resident #1 by NA #3. The resident ' s pillow case on one side, mattress cover (100-centimeter area) and back side of her pants and down the legs to the knees | F 157 | RN will ensure compliance by completing an audit all gastrostomy tubes port to ensure ports in place, properly functioning and there is no leakage completed by September 19,2017. The audit of gastrostomy tubes to ensure compliance will be completed by September 19, 2017. The audit will review all gastrostomy tube ports in the facility weekly to ensure proper management and no leakage until three months of compliance is sustained.<br><br>The Director of Nursing, Assistant Director of Nursing, or Staff Development RN will audit the 24hr nursing report to ensure any issues with leakage of gastrostomy tubes is reported to the physician. The audit will review the 24hr report three times a week for four weeks and then monthly for three months until three months of compliance is sustained.<br><br>These audits will be reviewed at least quarterly at QAPI-QA by the Administrator or Director of Nursing until three months of compliance is sustained. | |

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| F 157 | Continued From page 3 | F 157 | | |

were wet from tube feeding. When the resident was turned an accumulation of tube feeding was underneath the resident on the mattress.

On 8/21/17 at 2:00 pm an interview was conducted with Nurse #1. Nurse #1 stated that she received in report that the tube feeding had leaked for the past three days and none of the caps for the tubing port that were available had fit properly. Nurse #1 stated that the leak began when the physician changed the gastrostomy tube (in the hospital 8/2/17) to a multiple port tube and the cap was lost. Nurse #1 had not reported the leak to a nurse manager. Nurse #1 was aware that the leak was reported to the next assigned nurse during shift change and she was not aware if the physician was notified. Nurse #1 stated that staff had taped the port cap to stop the leak, but the leak had continued for the past three days.

On 8/22/17 at 2:15 pm an interview was conducted with Resident #1 ' s physician. The physician stated that he was not informed that a portion of the resident ' s tube feed had leaked into the bed for the past three days. The physician expected staff to inform him of resident changes and/or concerns. The physician stated that the resident had multiple co-morbidities (including severe osteoporosis) and was on a prescribed weight-gain regimen.

On 8/22/17 at 7:20 pm an interview was conducted with the Director of Nursing (DON). The DON stated that she expected staff to follow physician ' s orders and report any concerns. The DON had acquired and placed an appropriate cap for Resident #1 ' s gastrostomy tube leak and the leaking had stopped.

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| F 322 SS=D | 483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS<br><br>(g) Assisted nutrition and hydration.<br>(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and<br><br>(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, and staff interviews the facility failed to provide tube feeding care which resulted in leaking over three days and the potential for loss of nutrition and hydration and potential for aspiration in one of two residents (Resident #1).<br><br>Findings included:<br>Resident #1 was first admitted to the facility on 1/16/17 and admitted to Hospice 4/1217.<br><br>The quarterly Minimum Data Set dated 7/11/17 revealed Resident #1 had severely impaired cognition. The resident required total assistance | F 322 | On 8/21/2017 at approximately 2:30pm RN replaced cap on port to gastrostomy tube to stop leakage and ensure proper functioning of tube. On 8/21/2017 nursing assistant #3 was counseled and re-educated on aspiration precautions by Assistant Director of Nursing and on 8/23/2017 a written follow up to this conversation was given.<br><br>All licensed teammates (RN's/LPN's) were educated on management of gastrostomy tube ports by September 19,2017. All licensed teammates (RN's/LPN's) were | 9/19/17 |

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| F 322 | Continued From page 5<br>for activities of daily living and required one staff for feeding. The resident had a feeding tube and was on a physician ' s prescribed weight gain regimen. The resident ' s diagnoses were Alzheimer ' s disease, dementia without behaviors, adult failure to thrive, and dysphagia.<br><br>Resident #1 was admitted to the hospital on 7/30/17 for aspiration pneumonia and re-admitted to the facility on 8/2/17. The resident was diagnosed with pneumonitis due to inhalation of food and vomit. Hospice services were resumed on readmission to the facility.<br><br>Resident #1 ' s care plan dated 8/2/17 revealed goals and interventions for her gastrostomy tube and tube feedings.<br><br>Resident #1 had a physician ' s order dated 8/2/17 to keep the head of the bed (HOB) elevated during tube feeding.<br><br>A physician ' s order dated 8/9/17 revealed Osmolite 1.5 at 40 milliliters per hour (liquid nutritional supplement) through the gastrostomy tube.<br><br>On 8/21/17 at 11:40 am Resident #1 was lying in her bed with the HOB elevated and her gastrostomy tube feeding infusing at 40 milliliters per hour. The tube feeding was leaking from the tube port cap (extra port in addition to the tube feeding port) into the bed on to the pillow, sheets, mattress, resident ' s clothing, and the resident was sitting in a puddle of tube feeding. NA #3 entered the room to answer the roommate ' s call light, observed the resident and then left the room. No care was provided. | F 322 | educated on notification of changes to the resident; consult with residents physician and notify consistent with his or her authority, the resident representative(s) when there is a change.<br><br>All nursing teammates (RN/LPN/Nursing Assistants)were educated on proper positioning for residents with gastrostomy tubes, on aspiration precautions and reminded to have tube pump turned off by licensed nurse (RN/LPN) or Nursing Assistant II during personal care by September 19, 2017. All licensed teammates (RN/LPN) and Nursing Assistant II's were educated on how to turn off feeding during personal care by September 19, 2017.<br><br>The Director of Nursing, Assistant Director of Nursing or Staff Development RN will audit all residents with gastrostomy tubes port to ensure capping is in place and there is no leakage. The audit will review weekly observations of all gastrostomy tube ports in the facility to ensure proper management and no leakage. This audit will continue weekly for three consecutive months until three months of compliance is sustained.<br><br>These audits will be reviewed at least quarterly at QAPI-QA by the Administrator or Director of Nursing until three months of compliance is sustained.<br><br>The Director of Nursing, Assistant Director of Nursing or Staff Development | |

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| F 322 | Continued From page 6<br>On 8/21/17 at 12:45 pm Resident #1 was in her bed and the tube feeding was leaking at the tube port cap. NA #3 entered the room to answer the roommate ' s call light and observed the resident and left the room. No care was provided.<br><br>On 8/21/17 at 1:20 pm Nurse # 4 (Charge Nurse) was informed by the surveyor of Resident #1 ' s leaking tube feeding.<br><br>On 8/21/17 at 1:30 pm Nurse #1 (assigned to the resident) and Nurse #4 entered Resident #1 ' s room to evaluate the leaking tube feeding. The resident was lying in her bed with the head of the bed elevated. Her tube feeding was infusing into the gastrostomy tube at 40 milliliters per hour and into the bed and onto the resident. Nurse #1 replaced the same type of cap (only cap available). Nurse #1 directed NA #3 to change the linen and resident ' s clothing.<br><br>On 8/21/17 at 1:45 pm an observation was done of clothes and linen change for Resident #1 by NA #3. NA #3 began incontinence care by lowering the head of the bed. The tube feeding was infusing. NA #3 had not turned off the infusing tube feeding when the resident was lying flat until asked. There was no coughing or other signs of aspiration present for the resident. NA #3 called for assistance to provide care for the resident (care plan intervention required two staff members to provide care). The resident ' s pillow case on one side, mattress cover (100-centimeter area) and back side of her pants and down the legs to the knees were wet from tube feeding. When the resident was turned an accumulation of tube feeding was underneath the resident on the mattress. The resident ' s mattress was not cleaned. Clean linens were | F 322 | RN will also monitor weekly observation of one resident on gastrostomy tube receiving personal care by certified nursing assistant to ensure compliance for aspiration precautions. This audit will monitor proper placement head of bed and feeding pump being off during care.This audit will continue for weekly for three consecutive months until three months of compliance is sustained.<br><br>This audit will be reviewed at least quarterly at QAPI-QA by the Administrator or Director of Nursing until three months of compliance is sustained. | |

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| F 322 | Continued From page 7 | F 322 | | |

placed.

On 8/21/17 at 1:45 pm an interview was conducted with NA #3. NA #3 stated that she was required to turn off the tube feeding before lowering the head of the bed. NA #3 stated that she had not turned off Resident #1 ' s tube feeding before lowering the head of the bed. She had forgotten.

On 8/21/17 at 2:00 pm an interview was conducted with Nurse #1. Nurse #1 stated that she received in report that the tube feeding had leaked for the past three days and none of the caps for the tubing port that were available had fit properly. Nurse #1 stated that the leak began when the physician changed the gastrostomy tube to a multiple port tube and the cap was lost. Nurse #1 had not reported the leak to a nurse manager. The leak was reported to the next assigned nurse during shift change. Nurse #1 stated that staff had taped the port cap to stop the leaking, but the leak had continued for the past three days and the resident had to have her linen changed frequently. Nurse #1 stated that she worked on an as needed basis and was not familiar with Resident #1.
On 8/22/17 at 2:15 pm an interview was conducted with Resident #1 ' s physician. The physician stated that he was not informed that a portion of the resident ' s tube feed had leaked into the bed for the past three days. The physician expected staff to inform him of resident changes and/or concerns.

On 8/22/17 at 7:20 pm an interview was conducted with the Director of Nursing (DON). The DON stated that she expected staff to follow physician ' s orders and report any concerns.

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| F 322 | Continued From page 8<br>The DON had acquired and placed an appropriate cap for Resident #1 ' s gastrostomy tube leak and the leaking had stopped. | F 322 | | |
| F 441 SS=D | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections; | F 441 | | 9/19/17 |

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|---|---|---|---|---|
| F 441 | Continued From page 9<br>(iv) When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which 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; and<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, and staff interviews the facility failed to follow standard precautions for bodily fluids in 2 of 2 residents (Residents #1 and #2).<br><br>Findings included:<br>1. | F 441 | On 8/22/107 at approximately 7:30pm when Director of Nursing was notified by DHSR surveyor that bedside table had not been properly cleaned after dressing change on 8/21/2017 at 1:30pm the Director of Nursing had bedside table cleaned with disinfectant. On 8/21/2017 at | |

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| F 441 | Continued From page 10<br>Resident #1 was first admitted to the facility on 1/16/17 and admitted to Hospice servicers on April 12, 2017. The resident was re-admitted to the facility on 8/2/17 from the hospital for aspiration pneumonia.<br><br>The quarterly Minimum Data Set dated 7/11/17 revealed the resident had a severely impaired cognition. The resident was total dependence for activities of daily living of two staff members. The resident was incontinent of stool and urine.<br><br>Resident #1 ' s diagnoses were Alzheimer ' s disease, dementia without behaviors, pneumonitis due to inhalation of food and vomit, adult failure to thrive, and dysphagia.<br><br>Resident #1 ' s care plan dated 8/2/17 revealed goals and interventions for her skin tear.<br><br>The facility standard precautions policy dated 2/2014 revealed the facility used standard precautions for the care of all residents to eliminate or minimize occupational exposure to blood or body fluids. Staff was required to immediately have decontaminated or cleaned an exposed area following exposure. Hand hygiene procedure was according to corporate policy to change gloves when soiled. Activities which involved bloody or bodily fluid transmission were to be performed in a manner to prevent transmission.<br><br>On 8/21/17 at 1:30 pm an observation was done of wound care for Resident #1 by Nurse #1 and Nurse #4. The resident had a wrapped dressing over her skin tear that had moved down her arm and was no longer covering the tear. The skin tear had a non-adherent dressing and was bloody | F 441 | approximately 7:30pm when the Director of Nursing was made aware that on 8/21/2017 at 12:09am that bladder scanner was not properly cleaned before and after procedure, the Director of Nursing had bladder scanner properly cleaned with disinfectant. On 8/22/2017 at approximately at 7:30pm when the Director of Nursing was made aware that on 8/21/2017 1:40pm that a jar of incontinence cream was contaminated the Director of Nursing had the jar discarded. Director of Nursing had cream replaced with new jar.<br><br>All nursing teammates were educated on hand hygiene and standard and transmission based precautions, including removal of gloves when soiled.<br><br>All licensed nurses (RN's/ LPN's) and Nursing Assistant II's were educated on proper disinfecting of bladder scanner before and after every use.<br><br>All licensed nurses (RN's/ LPN's) and Nursing Assistant II's were educated on proper decontamination of exposed surface area after dressing change. These teammates also received education on proper hand hygiene and removal of gloves when soiled.<br><br>The Director of Nursing, Assistant Director of Nursing or Staff Development RN will conduct infection control observation audits monthly. These observations will include one observation of hand hygiene- disinfecting hands and | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345281 | A. BUILDING _____ B. WING _____ | C 08/22/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STANLY MANOR | 625 BETHANY CHURCH ROAD BOX 38 ALBEMARLE, NC 28001 |

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| F 441 | Continued From page 11<br>down her arm. Nurse #1 cleansed the skin tear with normal saline and placed the bloody soiled dressings on an uncovered bed-side table. The resident ' s skin tear was dressed and the soiled dressings were discarded. The bed-side table was not cleaned and clean items were placed on the table by Nurse #1.<br><br>On 8/212/17 at 1:40 pm an observation was done of incontinence care for Resident #1 by Nurse #1. Nurse #1 cleaned the resident ' s stool and then used the same gloves and handled the ointment jar, placed her hand into the jar and retrieved ointment, and then placed ointment onto the resident ' s labia and perineum. Nurse #1 was not observed to have changed her gloves after she cleaned the stool and proceeded to other care.<br><br>On 8/21/17 at 1:45 pm an interview was conducted with Nurse #1 and Nurse #4. Both Nurses stated they were done with Resident #1 ' s wound care and soiled wound care material discard and exited the room.<br><br>On 8/21/17 at 1:46 pm an interview was conducted with Nurse #1. Nurse #1 stated she used the same gloves to demonstrate incontinence care.<br><br>2.<br>Resident #2 diagnoses were dysphagia following cerebral infarction, gastrostomy, retention of urine, dysphagia, speech deficits, and benign prostate hypertrophy.<br><br>Resident #2 had a care plan dated 8/17/17 with goals and interventions for behaviors and interventions when care was refused, making | F 441 | glove usage, proper cleaning and disinfecting of work area with dressing change, one observation of hand hygiene -disinfecting hands and glove usage with incontinent care and one observation of disinfecting bladder scanner before and after usage.<br><br>These observations will be audited for three months until proper compliance is sustained. These audits will be discussed at least quarterly at the QAPI meetings by the Administrator or Director of Nursing. | |

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| F 441 | Continued From page 12 | F 441 | | |

himself understood, communication deficit, at risk for confusion, and bladder training and post void residual evaluation.
Physician ' s order dated 8/1/17 revealed bladder scan for urine every four hours, if the scanned amount was > 500 milliliters do an in and out catheter.

Facility bladder ultrasonography (scan) procedure date 2/3/17 revealed that the wand had to be cleaned before and after use with a disinfectant.

On 8/12/17 at 12:09 pm an observation of Resident #2 during his bladder scan was done. Nurse #8 informed the resident that she was going to scan his bladder for post void residual. The resident never moved, opened his eyes, or made any sound. During observation, no communication was identified between the resident and the staff. Nurse #8 lifted the bladder scan wand and placed the wand just above the groin. The wand was not cleaned before use. After the scan, Nurse #8 cleaned the wand with a peri wipe (not alcohol) and returned the wand to the holding cup.

On 8/12/17 at 12:20 pm an interview was conducted with NA #4. NA #4 stated that the resident was occasionally able to have made his needs known, but had garbled verbal communication. NA #4 indicated that the resident had not communicated this shift.
On 8/21/17 at 12:25 am an interview was conducted with Nurse #8. Nurse #8 stated that Resident #2 had an order for post void residual check by bladder scan every four hours. Nurse #8 stated that the resident was due for a scan and demonstrated what was required.

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| F 441 | Continued From page 13<br>On 8/22/17 at 7:35 pm an interview was conducted with Nurse #6. Nurse #6 stated that the bladder scan wand that was placed on the resident was required to be cleaned before and after use with alcohol. The use of peri wipes would not meet the criteria for standard precautions cleaning of the equipment.<br><br>On 8/22/17 at 7:20 pm an interview was conducted with the Director of Nursing (DON). The DON stated that she expected staff to follow the care plan and standard precautions for all bodily fluids. | F 441 | | |