

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

PRINTED: 02/01/2013
FORM APPROVED
OMB NO. 0938-0394

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345233	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/17/2013
NAME OF PROVIDER OR SUPPLIER SUNRISE REHABILITATION & CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 306 DEER PARK ROAD NEBO, NC 28761	
(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 242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interviews, the facility failed to accommodate resident's preference for time to get up in the morning for 2 of 3 residents (Residents #44 and #127) and frequency of showers a week for 1 of 3 residents (Resident #44) reviewed for choices.</p> <p>The findings are:</p> <ol style="list-style-type: none"> Resident #44 was readmitted on 06/15/12 with diagnoses including Alzheimer's Dementia. A quarterly Minimum Data Set (MDS) dated 12/05/12 revealed Resident #44 had moderately impaired cognition and was able to make her needs known. The quarterly MDS noted Resident #44 required one person physical assistance with bathing. <p>During an interview conducted on 01/14/13 at 3:21 PM Resident #44 stated did not have a choice regarding what time she got up in the morning or how many times a week she showered. Resident #44 further stated she received two showers a week but would prefer at least three showers a week as she had showered</p>	F 242	<p>Without admitting or denying the validity or existence of the alleged deficiencies, Sunrise Rehab and Care provides the following plan of correction</p> <p>F 242-SS=D</p> <ol style="list-style-type: none"> A. Resident #44 was interviewed regarding preferences for frequency of showers and for time to get up in the morning. Residents care plan and pictorial care card were reviewed and up dated according to resident's preferences. B. Resident #127 was interviewed regarding preference for get up time in the morning. Resident's care plan and pictorial care card were reviewed and up dated according to resident preference. Interview with current residents will be done by DON /designee regarding choices about his/her life that are significant to the resident. Admission Director will include explanation of choices during the admission process. Admitting nurse will document resident choices on the interim care plan and pictorial card. 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

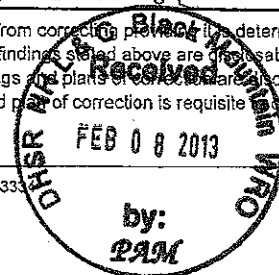
(X6) DATE

Winnie J. Allison

Administrator

02/07/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are reportable 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 reportable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite for continued program participation.



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F 242	<p>Continued From page 1</p> <p>daily prior to her admission to the facility. The interview further revealed Resident #44 did not like to get up early yet staff woke her at 6:30 AM every day and she would like to sleep until at least 7:30 AM.</p> <p>An interview with Nurse Aide (NA) #3 on 01/17/13 at 9:55 AM revealed the majority of residents were showered twice a week according to a master shower schedule which was based on room number. NA #3 stated there were a few residents who were scheduled for three showers a week but was not sure how residents were scheduled for additional showers.</p> <p>An interview was conducted with the facility's Admission/Marketing Director (AD) on 01/17/13 at 2:24 PM. During the interview the AD stated the resident and/or family member were asked if the resident preferred a shower or bath and if they liked to stay up after 8:00 PM during the admission process. The AD further stated residents received two showers a week unless the family requested additional showers. The interview further revealed residents and/or family members were not asked for the residents preference regarding the number of showers a week or what time they wanted to get up in the morning.</p> <p>During an interview on 01/17/13 at 2:40 PM the Director of Nursing (DON) revealed the shower list was assigned by room number but requests for additional showers were accommodated. The DON confirmed residents and/or family members were not asked for the residents preference regarding the number of showers a week or what time they wanted to get up in the morning.</p>	F 242	<p>Activity director to continue to ask preferences with section F on admission, annual and Significant change, MDS interviews and document responses in notes and update care plan/ pictorial card.</p> <p>3. Admission Director, nurses and Activity director will be in-serviced by DON/ADON on the process for obtaining and documenting resident choices.</p> <p>4. DON/ADON/QA Nurse/Designee will randomly audit residents regarding preferences and the facility's accommodations of those preferences weekly x 4, monthly x 2 then quarterly. Findings will be reported by the QA nurse at the monthly QA meetings.</p>	2-16-13	

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F 242	Continued From page 2 Based on record review and resident and staff interviews, the facility failed to accommodate resident's preference for time to get up in the morning for 2 of 3 residents (Residents #44 and #127) and frequency of showers a week for 1 of 3 residents (Resident #44) reviewed for choices. The findings are: 2. Resident #127 was readmitted on 08/31/12 with diagnoses including After care hip fracture and Generalized pain. A 60-day Minimum Data Set (MDS) dated 10/29/12 revealed Resident #127 was cognitively intact and was able to make her needs known. The quarterly MDS noted Resident #127 required one person physical assistance with transfers and walking in room. During an interview conducted on 01/15/13 at 8:52 AM Resident #127 stated she did not have a choice regarding what time she got up in the morning. Resident #127 further stated she would like to sleep until at least 8:00 AM yet staff woke her at 7:00 AM or earlier every day. Interview with Nurse #10 on 01/17/13 at 10:45 AM revealed a schedule of times to wake up residents is developed by the third shift nurses based on breakfast schedule, bath schedule, and the preferences of residents who have made their wake up time preferences known. Nurse 10 further revealed there was no assessment completed to find out residents' waking up time preferences and that the schedule of times to	F 242			

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F 242	Continued From page 3 wake up residents stayed the same over time except for the addition of newly admitted residents. Interview with Nurse Aide (NA) #2 on 01/17/13 at 11:15 AM revealed Resident #127 was one of the first residents she saw awakened daily when she started working on the floor between 6:45 and 7:00 AM. NA #2 further revealed she had never asked Resident #127 about her preferences about time to wake up in the mornings.	F 242			
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 staff interviews the facility failed to follow physician orders to obtain Hemocult tests for 1 of 10 sampled residents reviewed for unnecessary medications and laboratory test results. (Residents #34) The findings are: Resident #34 was admitted to the facility with diagnoses including anemia. A review of Resident #34's medical record revealed physician orders on 06/25/2012, 08/21/2012, and 11/14/2012 for the resident to have Hemocult stool testing performed, (tests for the presence of blood in stool) due to a decrease in Hemoglobin, Hematocrit, and Red Blood cells. A review of the resident's medical	F 281	F 281-SS=D 1. Resident #34's physician was notified regarding the orders not being completed and for any further orders for hemocult stool testing. 2. Don/Adon/ QA nurse/ designee will audit charts for the last 3 months to ensure orders have been followed. 3. Nurses were in-serviced by Don/ADON on responsibility to follow physician orders and to notify the physician of unable to do so ,for further instructions. 4. Don/ ADON /QA nurse /designee will randomly audit charts for completion and follow up of physician's orders weekly x4, monthly x 2 then quarterly. Findings will be reported by the QA nurse at the monthly QA meetings.	2-14-2013	

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F 281	Continued From page 4 record revealed staff failed to complete the Hemocult tests as ordered on 06/25/2012, 08/21/2012, and 11/14/2012. On 01/16/13 at 8:45 am Nurse #5 was interviewed and revealed she had reviewed Resident #34's medical records and was unable to find documentation that Hemocult #3 was completed for the order dated 11/14/2012. On 01/17/2012 1:50 PM Nurse #6 in an interview revealed she reviewed the medical record of Resident #34 and could find no documentation that Hemocult # 3 for the 06/25/2012 order was done or Hemocult #2 and #3 was done for the 08/21/2012 order. On 01/17/13 2:00 PM the Director of Nurses (DON) was interviewed and revealed her expectations were the nurses would document physician's orders in the nurse's notes and on the MAR. The DON also stated part of the procedure was for the nurse to inform the Nursing Aide's (NA's) when a specimen was required for testing and follow the facility procedure to save the stool specimen and then go get the nurse. The DON confirmed the Hemocult orders on 06/25/2012, 08/21/2012, and 11/14/2012 had not been completed as ordered.	F 281			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318	F318-SS=D 1. Resident #61's physician was notified, order obtained and resident was referred to OT and PT to evaluate and treat for PROM, contracture management, and restorative program.		

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F 318	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to treat a hand contracture with hand splint or range of motion services to prevent deterioration of contracture for 1 of 1 resident reviewed for range of motion.</p> <p>The findings are:</p> <p>Resident #61 was admitted in 2011 with diagnosis including Hypertension, Cerebrovascular Accident, and Depression. A significant change Minimum Data Set (MDS) completed 07/11/12 revealed Resident #61 was cognitively impaired and totally dependent in all ADL areas. The significant change MDS noted impairment on both sides of upper extremities for functional status.</p> <p>Interview with Nurse 8 on 01/14/13 at 2:15 PM revealed Resident #61 had a contracture on left hand but did not wear a splint or receive range of motion services.</p> <p>Review of an Occupational Therapy (OT) discharge summary dated 04/20/11 revealed Resident #61 was referred to Restorative Nursing with recommendations to apply splint to left upper extremity 6-8 hours per day and provide range of motion (ROM) exercises 5 days per week for left upper extremity. Occupational Therapy note dated 04/12/11 revealed Resident #61 was at risk of tone and range deterioration, skin breakdown, and functional decline.</p>	F 318	<p>2. Residents with decline in ROM/contractures as evident on last MDS will be reviewed and orders obtained for referrals to therapy as indicated. Restorative policy has been updated to include notification of the RN with any decline, refusal, treatment change, discontinuation or treatment put on hold.</p> <p>3. DON/ADON re-in-serviced RN and restorative aides on the restorative policy including the update.</p> <p>4. DON/ ADON/ QA nurse/ designee to audit restorative flow sheets weekly x 4, monthly x 2, then quarterly, to ensure there are no changes requiring a therapy referral. Reports to be given to QA nurse who will report to QA committee monthly.</p>	2-16-13	

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F 318	Continued From page 6 Review of Nursing Restorative Care Plan dated 04/20/11 revealed that "Restorative care does ROM and applies R hand splint 6-8 hours 5 x week. Range is fair." Weekly Restorative Flow Record notes dated between 4/27/11 and 7/8/11 revealed Resident #61 tolerated the ROM and wearing the splint for 6-8 hours daily well and continued to have fair range of motion with the left hand. Daily Restorative Flow Record notes dated between 07/11/11 and 07/15/11 revealed Resident removed the splint from left upper extremity within 15 minutes of the splint being put on. Restorative Nursing Note dated 07/17/11 revealed that Resident #61 was discontinued from Restorative Nursing services due to non-compliance. Quarterly MDS dated 10/03/12 revealed resident had no use of hands across all assessments, and left upper extremity range of motion was assessed as extremely poor. Interview with Occupational Therapist (OT) on 01/17/12 at 9:17 am revealed Restorative Nurse was to refer residents for assessment by OT whenever Restorative Nursing services were discontinued, so that resident's need for adaptation of splint or services can be evaluated. OT reported that no referral had been made for Resident #61 when Restorative Nursing services were discontinued on 07/27/11. Observation of Evaluation of Resident #61's need for splint and/or ROM services for upper left extremity by Physical Therapist (PT) and DON.	F 318			

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F 318	Continued From page 7 After evaluation, PT reported that there was evident atrophy in left had muscles from misuse during past 2 years. PT reported that Resident #61 could benefit from splint and ROM services in order to maintain functional status. PT reported left upper extremity had extremely poor range and had deteriorated since Restorative Nursing services were discontinued in July of 2011. Interview with Laura Chapman, Director of Nursing (DON) on 01/17/13 at 1:20 PM revealed her expectation that when restorative nursing was discontinued, physician should be contacted for new order and new referral will be made to Physical or Occupational therapy to assess for needs.	F 318		
F 371 SS=E	483.35(f) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or 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 and interviews the facility failed to maintain cleanliness of 2 of 2 nutrition pantries and use proper hand washing technique when moving from the dirty to the clean area of the dish line.	F 371	F-371-SS=E 1. A North and South Pantry was cleaned and sanitized by Housekeeping staff immediately. B. Dietary Aide # 1 was re-in-serviced on infection control policies. 2. A C NA daily assignment sheets revised to be more specific in regards to cleaning responsibilities. 1st shift housekeeper was in-serviced on the responsibilities in regards to the pantries.	

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F 371	Continued From page 8 The findings are: 1.a. An observation of the north unit nutrition pantry on 01/14/13 at 9:31 AM revealed the following: - microwave with dried food splattered on the walls and turntable - 10 pieces of dried cereal on the bottom shelf of a cabinet over the sink - a wrapped ham and cheese sandwich dated 01/11/13 in a cabinet over the refrigerator - dried coffee grounds, 8 inch by 4 inch dried dark brown spill, a large pile of crumbs, and single serving jelly packet sticky to the touch in a cabinet which contained approximately 15 reusable resident water pitcher straws. - coffee grounds and dried coffee spills on counter next to coffee pot - all lower cabinet doors and drawers had dried white spills down the front that were sticky to the touch. Subsequent observations of the north unit nutrition pantry on 01/14/13 at at 4:50 PM, 01/15/13 at 9:55 AM, and 01/15/13 at 3:45 PM revealed no changes in the condition of the nutrition pantry from the initial observation on 01/14/13 at 9:31 AM. During an interview on 01/15/13 at 3:14 PM Nurse Aide (NA) #4 and NA #5 stated they were responsible for cleaning up the nutrition pantry at the end of the 3:00 PM to 11:00 PM shift. NA #4 and NA #5 explained they took dirty dishes to the kitchen, wiped up the counters, swept up the floor if needed, and checked the refrigerator to be sure food items had a name and date. Neither NA	F 371	3. A. CNA staff has been in-serviced by DON on the duties related to the pantries. Housekeeping staff has been in-serviced by EES in regards to the duties related to the pantries. B. Dietary staff has been in-serviced on hand washing and infection control policies by Dietary Manager. 4. DON/ ADON/ QA Nurse/ designee to audit pantries for cleanliness weekly x4, monthly 2, then quarterly. Report to be given at QA nurse who will report to QA committee monthly. Dietary Manager or designee to audit pantries for cleanliness weekly ongoing. Dietary Manger will randomly observe infection control/handwashing technique of 1 dietary staff member weekly x 4, monthly x 2 then quarterly. Dietary Manager will report findings of both audit and observations at the monthly QA meeting.	2-16-13	

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F 371	<p>Continued From page 9</p> <p>knew who was responsible for cleaning the inside of the cabinets.</p> <p>On 01/15/13 at 3:45 PM the Director of Nursing (DON) observed the north unit nutrition pantry and stated the current condition of the pantry was not acceptable. The DON further stated NAs are assigned to clean the nutrition pantry daily and she expected them to clean off the counter tops and the inside of the cabinets. The DON confirmed the microwave was used to heat up resident's food and she expected the NAs to clean the microwave. The interview further revealed 1st shift (6:00 AM-2:00 PM) housekeeping staff was responsible for sweeping and mopping the pantry floor, cleaning the counter tops, and cleaning the front of the drawers and cabinets. The DON also stated she did not routinely check the pantries to make sure cleanliness was maintained.</p> <p>An interview with the Maintenance Supervisor and Housekeeping Supervisor on 01/16/13 at 8:50 AM revealed the 1st shift housekeeper were trained to clean the pantries daily and round on both pantries twice during their shift. The Maintenance Supervisor stated the housekeepers were expected to disinfect the counters, sweep and mop the floors, clean the fronts of the cabinets and drawers, and empty the trash. Both Supervisors stated they did not make any formal rounds of the facility to make sure cleanliness was maintained satisfactorily in the nutrition pantries.</p> <p>During an interview the 1st shift housekeeper stated she was responsible for sweeping and mopping the pantries, cleaning the counters, and</p>	F 371			

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F 371	<p>Continued From page 10</p> <p>taking out the trash. The housekeeper further stated she had mopped both pantries on 01/14/13 and 01/15/13 and must have overlooked the fronts of the cabinets and drawers.</p> <p>b. An observation of the south unit nutrition pantry on 01/14/13 at 9:47 AM revealed the following:</p> <ul style="list-style-type: none"> - a quarter-sized yellow dried spill on the floor in front of the refrigerator that was sticky to the touch - coffee grounds and dried coffee spills on counter next to coffee pot - all lower cabinet doors and drawers had dried white spills down the front that were sticky to the touch. - coffee grounds and food crumbs noted on shelves in a cabinet under the coffee maker which contained resident feeding equipment. <p>Subsequent observations of the south unit nutrition pantry on 01/14/13 at 4:55 PM, 01/15/13 at 8:50 AM, and 01/15/13 at 3:35 PM revealed no changes in the condition of the nutrition pantry from the initial observation on 01/14/13 at 9:47 AM.</p> <p>An interview with NA #6 on 01/15/13 at 3:30 PM revealed NAs were responsible for cleaning up the pantry during the 3:00 PM to 11:00 PM shift. NA #6 explained they brought any meal trays to the kitchen, checked the refrigerators for unlabeled food items, and emptied the trash if needed. NA # was not sure who was responsible for cleaning the inside of the cabinets but thought it was the 7:00 AM to 3:00 PM shift.</p> <p>On 01/15/13 at 3:35 PM the Director of Nursing</p>	F 371			

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NAME OF PROVIDER OR SUPPLIER SUNRISE REHABILITATION & CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 306 DEER PARK ROAD NEBO, NC 28761		
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F 371	<p>Continued From page 11</p> <p>(DON) observed the south unit nutrition pantry and stated the current condition of the pantry was not acceptable. The DON further stated NAs are assigned to clean the nutrition pantry daily and she expected them to clean off the counter tops and the inside of the cabinets. The DON confirmed the microwave was used to heat up resident's food and she expected the NAs to clean the microwave. The interview further revealed 1st shift (6:00 AM-2:00 PM) housekeeping staff was responsible for sweeping and mopping the pantry floor, cleaning the counter tops, and cleaning the front of the drawers and cabinets. The DON also stated she did not routinely check the pantries to make sure cleanliness was maintained.</p> <p>An interview with the Maintenance Supervisor and Housekeeping Supervisor on 01/16/13 at 8:50 AM revealed the 1st shift housekeeper were trained to clean the pantries daily and round on both pantries twice during their shift. The Maintenance Supervisor stated the housekeepers were expected to disinfect the counters, sweep and mop the floors, clean the fronts of the cabinets and drawers, and empty the trash. Both Supervisors stated they did not make any formal rounds of the facility to make sure cleanliness was maintained satisfactorily in the nutrition pantries.</p> <p>During an interview the 1st shift housekeeper stated she was responsible for sweeping and mopping the pantries, cleaning the counters, and taking out the trash. The housekeeper further stated she had mopped both pantries on 01/14/13 and 01/15/13 and must have overlooked the fronts of the cabinets and drawers.</p>	F 371			

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F 371	Continued From page 12 2. During an initial tour of the kitchen on 01/14/13 at 9:01 AM Dietary Aide #1 was observed wearing disposable gloves on both hands rinsing food debris from residents' breakfast dishes and placing them on a rack in front of the dishwasher on the dish line. At 9:03 AM Dietary Aide #1 moved to a rack of dishes at the other end of the dish washing line without removing her disposable gloves and washing her hands. Dietary Aide #1 picked up a mug and a plate dome and placed them on a nearby metal rack. Dietary Aide #1 was interrupted before she continued any further and confirmed she had touched clean dishes while wearing the pair of disposable gloves she wore while rinsing the dirty dishes. Dietary Aide #1 stated she had been trained to remove her gloves, wash her hands, and put on a clean pair of disposable gloves when she moved from the dirty to the clean area of the dish washing process. An interview with Dietary Manager (DM) on 01/14/13 at 9:05 AM revealed she had observed Dietary Aide #1 touch the clean dishes with the same gloves she had worn while rinsing food debris from residents' breakfast dishes. The DM stated Dietary Aide #1 should have removed her disposable gloves, washed her hands, and put on	F 371			

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F 371	Continued From page 13 a clean pair of disposable gloves before handling clean dishes. The DM further stated all dietary staff were educated regarding proper hand washing during their orientation and also were instructed regarding the dish washing procedure during their orientation to the kitchen.	F 371			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431	F 431-SS=D 1. Expired PPD vials were immediately discarded. 2. Nurses on duty instructed to check all cabinets, refrigerators, and med carts for expired meds. Refrigerator temperature audit sheet was revised to include a check for expired meds in refrigerator weekly by third shift nurses. Pharmacy consultant to continue audit for expired meds every month. An updated guideline for medication expiration dates was put on front of each medication refrigerator and in front of all MAR's. 3. Nurses in-serviced by DON on procedure change. 4. DON/ADON/QA/other designee to audit Med Room refrigerators for expired meds weekly x 4 then monthly x2, then quarterly. Reports to be given to QA nurse who will report to the QA committee monthly.	2-16-13	

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F 431	<p>Continued From page 14</p> <p>quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to discard two multi-dose vials of Tuberculin Purified Protein Derivative (PPD) that were expired in 2 of 2 medication refrigerators available for use.</p> <p>The findings are:</p> <p>On 01/15/2013 at 11:00 AM the medication refrigerator on the North Hall was checked for expired drugs. There was one opened vial of PPD dated 12/08/2012. Posted on the front of the refrigerator was the following information: "Policy: All multi-dose vials of injectable medications and vaccines shall be dated by the designated staff person at the time that the seal is broken and the first dose drawn. Subsequently, the following expiration dates shall be observed: 30 Days: PPD"</p> <p>During an interview on 01/15/2013 at 11:10 AM with Nurse #5; who assigned to the North Hall; confirmed the PPD vial was open and dated 12/08/2012. Nurse #5 revealed the facility policy was for vials of PPD to be dated when opened and discarded after 30 days. Nurse #5 confirmed the PPD vial dated 12/08/2013 was past the 30 days expiration and should be thrown away immediately.</p> <p>On 01/15/2013 at 11:15 AM the medication</p>	F 431		
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F 431	<p>Continued From page 15</p> <p>refrigerator on the South Hall was checked for expired drugs. There was one opened vial of PPD dated 12/04/2012. Posted on the front of the refrigerator was the following information: "Policy: All multi-dose vials of injectable medications and vaccines shall be dated by the designated staff person at the time that the seal is broken and the first dose drawn. Subsequently, the following expiration dates shall be observed: 30 Days: PPD."</p> <p>During an interview on 01/15/2013 at 11:20 AM with Nurse #4; who assigned to the South Hall; confirmed the PPD vial was open and dated 12/04/2012. Nurse #4 revealed she was new to the facility and not sure what the facility policy was for multi-dose vials of PPD. Nurse #4 confirmed the posting on the refrigerator that stated PPD vials were to be discarded 30 days after opening. Nurse #4 confirmed the PPD vial dated 12/04/2012 was expired and should be thrown away immediately.</p> <p>During an interview on 01/16/2013 at 12:45 PM the Facility Clinical Nurse Consultant revealed the manufacturer's recommendations for PPD were the vials were to be dated when opened and discarded after 30 days of opening. She confirmed she expected the facility staff to follow this directive and if a PPD vial was found to be past the 30 days expiration it was to be thrown away immediately.</p> <p>On 01/15/2013 at 1:00 PM in an interview the Director of Nurses (DON) stated her expectations were for nursing staff to follow the facility policy to date PPD vials when opened, to routinely check all multi-dose vials for dates and discard any past</p>	F 431		
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F 431	Continued From page 16 the posted expiration dates.	F 431		
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	F 441-SS=D 1. Nurse # 1 was re-in-serviced on washing hands between resident contact. 2. All residents have the potential to be affected. 3. Nurses were re-in-serviced by Staff Development, QA / Risk management nurses on proper hand washing technique and use of disposable gloves with blood glucose monitoring with return demonstration of correct procedures. 4. DON/ADON/QA Nurse/other designee to randomly audit nurses during med passes for proper procedure weekly x 4, monthly X2, then quarterly. Report to be given to QA nurse who will report to QA committee monthly.	2-16-13

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F 441	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, policy review and staff interviews the facility failed to wash hands between residents during finger stick blood glucose testing of 3 of 3 sampled residents (Residents # 24, 85 and 90).</p> <p>The findings are:</p> <ol style="list-style-type: none"> Review of a facility policy titled "Policy on Handwashing During the Provision of Resident Care" updated 07/21/11, revealed employees must wash their hands under the following circumstances; before and after performing any invasive procedure such as a finger stick blood glucose. <p>On 01/15/13 at 3:30 PM a continuous observation was made of Nurse #1 obtaining three finger stick blood glucose tests. Nurse #1 donned a pair of gloves, prepared Resident #24's finger and obtained the finger stick blood glucose test. Nurse #1 removed her gloves prior to leaving Resident #24's room and without washing her hands, returned to the medication cart, reapplied gloves and cleaned the blood glucose meter. After cleaning the blood glucose meter, Nurse #1 gathered supplies and entered Resident #85's room, donned clean gloves and performed a finger stick blood glucose test. Nurse #1 removed her gloves prior to leaving Resident #85's room and without washing her hands, returned to the medication cart, reapplied gloves and cleaned the blood glucose meter. After</p>	F 441		
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F 441	<p>Continued From page 18</p> <p>cleaning the blood glucose meter, Nurse #1 gathered supplies and entered Resident #90's room, donned clean gloves and performed a finger stick blood glucose test. Nurse #1 removed her gloves prior to leaving Resident #90's room and without washing her hands, returned to the medication cart, reapplied gloves and cleaned the blood glucose meter.</p> <p>On 01/15/13 at 4:15 PM Nurse #1 was interviewed and acknowledged she did not wash her hands between residents while performing finger stick blood glucose testing. Nurse #1 revealed she should have washed her hands between residents.</p> <p>An interview with the Director of Nursing on 01/15/13 at 4:40 PM revealed it is her expectation that staff wash their hands between residents and indicated gloves are not a substitution for hand hygiene.</p>	F 441		