**Disclaimer for Plan of Correction**

Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Christian Care Center of Bedford County of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Christian Care Center of Bedford County files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings do not exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings.

F 315

Christian Care Center of Bedford County believes its current practices were in compliance with the applicable standards of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:

[Signature]

Administrator

5/18/11
Corrective Actions for Targeted Residents

CNA #1 (providing care for Resident #7) was immediately pulled from her duties on 5/4/11 after the Director of Nursing Interview with the state surveyor. The ADON provided retraining on perineal care. CNA #1 was noted to be in 100% compliance with the procedure by return demonstration on 5/5/11 and allowed to return to duty on that date. Resident #7 is currently receiving appropriate perineal care as outlined in the facility's policy.

Identification of Other Residents with Potential to be Affected

Due to the nature of this practice, current residents receiving incontinent care have the potential to be affected.

Systematic Changes

Currently employed CNA's will be educated by the ADON beginning 5/17/11 and to be completed by 5/31/11 regarding the need to provide perineal care following the facility's policy.

Currently employed CNA’s will be observed by the ADON in their perineal care technique by 5/31/11. Retraining will be provided as necessary.

Newly hired CNA staff will be in-services on perineal care and observed by the
**SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY CITATION IDENTIFYING INFORMATION)**

**F 319**  
Continued from page 1  
Lack of proper infection control practices.  
Observations in resident #70's room on 5/8/11 at 4:00 PM, CNA #1 did perineal care using back and forth instead of moving front to back on the same side of the cloth. CNA #1 used the same towel on the perineal area she had used on resident #70's anal area. CNA #1 cleaned perineal area in a back and forth motion without changing sides of the towel.  

**F 322**  
Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy-tube receives the appropriate treatment and services to prevent aspiration pneumonias, diarrhea, vomiting, dehydration, metabolic abnormalities, and naso-pharyngeal ulcerations and to restore, if possible, normal eating skills.  

This REQUIREMENT is not met as evidenced by:  
Based on a review of observation and interview, it was determined the facility failed to ensure staff followed the procedure for switching placement and resite of the naso-gastric tube, Gastrostomy Stomach (PEG) tube for #1 resident.  

**F 815**  
ADON prior to the end of their orientation period.  

**Monitoring**  
The ADON will monitor CNA's performing perineal care to ensure that the facility policy is being followed. A 10% sample of CNA's will be monitored during perineal care each month for 3 months. The ADON will report these findings to the Performance Improvement Committee monthly for review and determination of ongoing compliance. This committee will consists of the Medical Director, Administrator, Director of Nursing, Social Service Director, Activity Director, Dietitian, Maintenance Supervisor, Medical Records and Housekeeping Supervisor.  

**5/31/11**  

**F 322**  
Christian Care Center of Bedford County believes its current practices were in compliance with the applicable standards of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:  

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REQUIREMENT)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 319</td>
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<td>F 815</td>
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<td></td>
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<tr>
<td>F 322</td>
<td></td>
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<td>Monitoring</td>
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</tbody>
</table>
F 322 Continued from page 2:
(Resident #8) sampled resident observed receiving medication per a PEG tube.

The findings included:

- Review of the facility's "Medication Administration: Feeding Tube" policy documented, "...verify tube placement using esophageal technique. a. Unclamp tube and use either of the following procedures: (1) Insert a small amount of air into the tube within a syringe, and aspirate stomach with a flexible scope for gurgling sounds; or (2) Aspirate stomach...". Resident #8 was not observed to aspirate stomach contents at facilities.

Observations in Resident #8's room on 5/21/11 at 8:55 AM: Nurse #2 administered medications per PEG tube to Resident #8. Nurse #2 failed to check the PEG tube placement per aspiration or check for residual prior to administration of medications per the PEG tube.

During an interview at nursing station #1 on 5/21/11 at 8:35 AM, the Director of Nursing stated, "...the likely failure...nurse check the PEG tube insertion per aspiration or check for residual prior to medications...will review the policy on PEG tubes." • F 431

F 431
488.900 (4) (4) DRUG RECORDS, LABELS, STORAGE DRUGS & BIOLOGICALS

The facility must employ the services of a licensed pharmacist who establishes a system of records, procedure, and disposition of all controlled drugs in sufficient detail to ensure an accurate reconciliation, and determines that drug records are in order and that all

Corrective Actions for Targeted Residents

Nurse #2 (providing care for Resident #8) was verbally instructed by the DON on 5/16/11 on the policy and procedure for administration of medications via PEG tube. Nurse #2 was noted to be in 100% compliance upon return demonstration of the procedure. Resident #8 is currently receiving medication via PEG tube per facility policy.

Identification of Other Residents with Potential to be Affected

Due to the nature of this practice, current residents receiving medication via a PEG tube have the potential to be affected.

Systematic Changes

Licensed nursing staff will be educated by the DON on the proper medication administration via PEG tube starting on 5/17/11 and completed by 5/31/11. Currently employed licensed nursing staff will be observed by the DON when performing medication administration via PEG tube. This will be completed by 5/31/11. Retraining will be provided as necessary.

Newly hired licensed nurses will be involved and observed by the DON for compliance with medication administration via a PEG tube prior to the end of their orientation period.
**F.431** Continued From page 3

Controlled drugs as maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with current accepted professional principles and include appropriate expiration 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 1970 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This requirement is not met as evidenced by:

Based on observations and interview, it was determined the facility failed to ensure medications were stored in locked compartments when not in use and the following were noted:

<table>
<thead>
<tr>
<th>Name</th>
<th>Medication</th>
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<tbody>
<tr>
<td>Dr. Smith</td>
<td>Morphine</td>
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<tr>
<td>Mrs. Green</td>
<td>Vicodin</td>
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</tbody>
</table>

The findings included:

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<tr>
<th>Phase</th>
<th>Action</th>
</tr>
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<tbody>
<tr>
<td>Initial</td>
<td>Corrective Action Plan</td>
</tr>
<tr>
<td>Follow-up</td>
<td>Action Plan Evaluation</td>
</tr>
</tbody>
</table>

(Monitoring)

The Director of Nursing will monitor a 10% sample of Licensed Nurses administering medications via a PEG tube each month for 3 months. The DON will report these findings to the Performance Improvement Committee monthly for review and determination of ongoing compliance. This committee consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Assessment Nurse, Social Service Director, Activity Director, Dietary Manager, Maintenance Director, Medical Records and Housekeeping Supervisor.

5/31/11

**F.431**

Christian Care Center of Bedford County believes its current practices were in compliance with the applicable standards of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:

**Corrective Actions for Targeted Residents**

On 5/16/11, Nurses #1 and #3 were verbally instructed by the DON on the
**F 431** Continued from page 4

1. Observations in Random Resident #4's room on 6/11/11 at 6:40 PM. Nurse #1 placed a tube of Erythromycin eye ointment on the overbed table. Nurse #1 left the room to wash her hands and left the medication unattended and out of her sight.

Observations in Random Resident #4's room on 6/11/11 at 8:35 AM. Nurse #1 placed a Nalgene bottle of Donor's potty on the overbed table. Nurse #1 left the room to enter the bathroom to wash her hands and left the medication unattended and out of her sight.

2. Observations in Random Resident #2's room on 6/21/11 at 4:27 PM. Nurse #3 placed the Syringe Lubricant eye drops on the overbed table. Nurse #3 left the room to enter the bathroom to wash her hands and left the medication unattended and out of her sight.

3. During an interview at nurse's station 1 on 6/4/11 at 8:45 AM, the Director of Nursing confirmed that medications should not be left unattended by the nurse.

**F 441**

**483.48 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-

- policy and procedure for medication administration and storage, specifically not leaving medications unattended.
- Nurses #1 and #3 were compliant upon return demonstration of the procedure to the DON on 5/16/11.
- Random Residents #1, #2 and #4 are receiving medications per facility policy and procedures.

**Identification of Other Residents with Potential to be Affected**

Due to the nature of this practice, current residents have the potential to be affected.

**Systematic Changes**

Beginning 5/17/11, with completion by 5/31/11, licensed nursing staff will be in-serviced on the proper administration and storage of medications, particularly not leaving medications unattended. This in-service will be conducted by the DON with return demonstration by Nursing Staff.

Newly hired nurses will be in-serviced by the DON and observed during their orientation period by the DON on the proper policy and procedure for administration/storage of medications, particularly not leaving medications unattended.
F 431 Continued from page 4

1. Observations in Random Resident #1's room on 8/24/11 at 8:48 PM, Nurse #1 placed a tube of Erythromycin eye ointment on the overbed table. Nurse #1 left the room to enter the bathroom to wash his hands and left the medication unattended and out of his sight.

Observations in Random Resident #4's room on 9/3/11 at 4:56 AM, Nurse #1 placed a Nitroglycerin Transdermal Patch on the overbed table. Nurse #1 left the room to enter the bathroom to wash her hands and left the medication unattended and out of her sight.

2. Observations in Random Resident #2's room on 5/23/11 at 4:27 PM, Nurse #3 placed Square Lubricant eye drops on the overbed table. Nurse #3 left the room to enter the bathroom to wash her hands and left the medication unattended and out of her sight.

3. During an interview at Nurses Station 1 on 5/23/11 at 8:35 AM, the Director of Nursing confirmed that medications should not be left unattended by the nurse.

F 441

459.90 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 diseases and infections:

(a) Infection Control Program
The facility must establish an Infection Control Program under which it

F 441

Monitoring

The DON will conduct an audit of 10% of the Nursing Staff monthly for 3 months to observe for compliance of policy and procedure regarding medication administration/storage -- particularly not leaving medications unattended. The DON will report these findings to the Performance Improvement Committee monthly for review and determination of ongoing compliance. This committee consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Assessment Nurse, Social Service Director, Activity Director, Dietary Manager, Maintenance Director, Medical Records and Housekeeping Supervisor.

5/31/11

Christian Care Center of Bedford County believes its current practices were in compliance with the applicable standards of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:
**Corrective Actions for Targeted Residents**

An isolation sign was placed on the door of resident #5's room by the DON on 5/4/11 after interview with the DON by the state surveyor.

ADON educated CNA's #7, #10, #11 and #12 on 5/17/11 on sanitary hand hygiene during dining.

Sanitary hand hygiene is being practiced during dining for random resident #3 and residents in Rooms #32, 37 and 38.

**Identification of Other Residents with Potential to be Affected**

Due to the nature of this practice, current residents on isolation have the potential to be affected.

Due to the nature of this practice, current residents that dine in the facility have the potential to be affected.

**Systematic Changes**

Current nursing staff will be in-services on the requirement of placing a sign on the door of resident rooms when the resident is placed on isolation, per the facility policy. This training will be conducted by the ADON beginning on 5/17/11 with completion by 5/31/11.

Newly hired licensed nursing staff will be in-services by the ADON on the facility.
F-441 Continued. From page 5:
proper signage was placed at the door of:
Random Resident (RR) #3, who was in contact isolation.

The findings included:
1. Review of the facility's "CNA Training Advisor" guidelines documented, "...wash hands before and after any resident contact..."

2. Medical record review for RR #3 documented an admission date of 2/7/11 with diagnosis of cellulitis and abscess of buttock, need for isolation, history of fall and other disorders of bone. Physician's orders dated 5/11/11 documented, "Contact Isolation Precautions.",

Observation in RR #3’s room (room #75) on 5/3/11 at 7:30 AM, revealed CNA #7 delivered a breakfast tray to RR #3, assisted RR #3 to position in the wheelchair, tucked the overbed table, then set up the tray without washing her hands or applying gloves. The surveyor stopped CNA #7 as she was stepping out of the resident’s room and asked CNA if she was aware RR #3 was in isolation. CNA #7 then asked another CNA (CNA #8) if RR #3 was in isolation. CNA #8 stated, "Yes, contact." CNA #7 then walked back into RR #3’s room and washed her hands. There was no contact isolation sign posted outside the room to acknowledge RR #3 was in contact isolation.

During an interview in the family room on 6/4/11 at 9:22 AM, the Director of Nursing (DON) was asked how staff and visitors know when a resident is in isolation. The DON stated, "We put a sign on the door."
F 441 Continued From page 7

3. Observations in room 38 on 6/8/11 at 8:00 AM, CNA #10 moved a chair to the bedside, raised the resident's head of bed, opened the milk and food, and did not wash her hands before feeding the resident.

Observations in room 37 on 6/3/11 at 8:17 AM, CNA #10 turned on the light, raised the head of the bed, turned off the alarm, put a towel across the resident, took the top off the plate, opened the milk and the straw. CNA #10 did not wash her hands before feeding the resident.

4. Observations in room 32 on 6/8/11 at 8:05 AM, CNA #11 pulled the resident up in bed, elevated the foot and the head of the bed, moved the overbed table to the resident and did not wash her hands before she opened the milk for the resident.

5. Observations in room 32 on 6/3/11 at 8:11 AM, CNA #12 pulled the resident up in bed, raised the head of the bed and did not wash her hands before she opened the items on the resident's tray.

F 444 MDS Coordinator, Assessment Nurse, Social Service Director, Activity Director, Dietary Manager, Maintenance Director, Medical Records and Housekeeping Supervisor.

The ADON will monitor hand hygiene during dining five times a week for four weeks, and then quarterly to ensure hand hygiene is performed per facility policy. The ADON will report these findings to the Performance Improvement Committee monthly for review and determination of ongoing compliance. This committee consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Assessment Nurse, Social Service Director, Activity Director, Dietary Manager, Maintenance Director, Medical Records and Housekeeping Supervisor.

5/31/11