<table>
<thead>
<tr>
<th>F 164</th>
<th><strong>483.10(e), 483.75(f)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>P 164</strong></td>
<td>This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that it was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</td>
</tr>
</tbody>
</table>

1. Residents #1, 3 and 5's MARs were covered immediately.
2. All residents will have confidentiality of their records maintained by covering the MARs.
3. All nurses will be in-service on confidentiality of maintaining records. The Unit Manager or designee will monitor confidentiality of MARs periodically. If any issues of non-compliance are found they will be corrected immediately and referred to the QA Committee for corrective action.
4. The Unit Manager will report all results of monitoring audits to the QA Committee who will review and implement corrective measures as necessary.

---

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

- **PROVIDER/SUPPLIER IDENTIFICATION NUMBER**: 445816
- **DATE SURVEY COMPLETED**: 02/16/2011
- **NAME OF PROVIDER OR SUPPLIER**: HILL CREST HEALTHCARE CENTER
- **STREET ADDRESS, CITY, STATE, ZIP CODE**: 111 E PEMBERTON STREET, ASHLAND CITY, TN 37015

**SUMMARY STATEMENT OF DEFICIENCIES**

Each deficiency must be preceded by full regulatory or local identifying information.

**PROVIDERS PLAN OF CORRECTION**

Each corrective action should be cross-referenced to the appropriate deficiency.

**DATE COMPLETION**

3/16/11

---

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

---

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 patient. (See Instructions.) Except for nursing homes, the findings stated above are disclosedable 80 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 disclosedable 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.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFIENCIES (EACH DEFICIENCY MUST BE PRECISELY DESCRIBED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 164</td>
<td>Continued from page 1</td>
<td>Medication Administration Record (MAR). The findings included: 1. Review of the &quot;Medication Guide for the Long-Term Care Nurse&quot; sixth edition, page 60 documented, &quot;Remember to protect confidentiality of patient records, including the MAR book. The nurse should fill the MAR pages face down when the book is unattended.&quot; 2. Observations outside of Random Resident (RR) #1's room on 2/14/11 at 2:05 PM, Nurse #1 left the MAR open, revealing the resident's information in public view to anyone who passed by. 3. Observations outside RR #3's room on 2/14/11 at 3:35 PM, Nurse #3 left the MAR open, revealing the resident's information in public view to anyone who passed by. 4. Observations outside RR #8's room on 2/15/11 at 7:30 PM, Nurse #8 left the MAR open, revealing the resident's information in public view to anyone who passed by. 483.16(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on policy review and observations, it was determined the facility failed to ensure 2 of 9 (483.16(a))</td>
<td>F 164</td>
</tr>
</tbody>
</table>
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(K1) PROVIDER/SUPPLIER/ICA IDENTIFICATION NUMBER</th>
<th>(K2) MULTIPLE CONSTRUCTION A. BUILDING</th>
<th>(K3) DATE SURVEY COMPLETED</th>
</tr>
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<tbody>
<tr>
<td>445318</td>
<td>B. WING</td>
<td>02/16/2011</td>
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</table>

**NAME OF PROVIDER OR SUPPLIER**  
HILLCREST HEALTHCARE CENTER  
STREET ADDRESS, CITY, STATE, ZIP CODE  
111 E PEMBERTON STREET  
ASHLAND CITY, TN 37015

<table>
<thead>
<tr>
<th>(K4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(K5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 241</td>
<td>Continued From page 2 nurses (Nurses #4 and 6) and 1 of 7 Certified Nursing Assistants (CNA #1) knocked on the door or gained permission prior to entering the resident's room. The findings included: 1. Review of the facility's &quot;Quality of Life&quot; policy documented, &quot;All staff respect resident's private space and property, including, but not limited to: Knocking on resident's door and requesting permission to enter.&quot; 2. Observations outside Resident #9's room on 2/15/11 at 12:35 PM and 12:36 PM, CNA #1 entered Resident #3's room without knocking or gaining permission to enter. 3. Observations in Random Resident (RR) #6's room on 2/15/11 at 12:10 PM, Nurse #4 entered RR #6's room without knocking or gaining permission to enter. 4. Observations in RR #9's on 2/15/11 at 7:29 PM, Nurse #6 entered RR #9's room without knocking or gaining permission to enter. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/SUPER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility failed to</td>
<td>F 241</td>
<td>F 282</td>
<td>2) All nurses and caregivers will be instructed to knock on doors and request permission to enter for all residents prior to entry. 3) The Staff Development Coordinator or designee will monitor knocking on doors and request permission to enter periodically. If any issues of non-compliance are found they will be corrected immediately and referred to the QA Committee for corrective action. 4) The Staff Development Coordinator will report all results of monitoring audits to the QA Committee who will review and implement corrective measures as necessary.</td>
</tr>
<tr>
<td>F 282</td>
<td>F 282</td>
<td>3/16/11</td>
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</table>

FORM CMS-3900(02-09) Previous Versions Obsolete Event ID: 5FNN11 Facility ID: TN1102 If continuation sheet Page 3 of 28
Department of Health and Human Services
Centers for Medicare & Medicaid Services

Statement of Deficiencies and Plan of Correction

Provider/Supplies Identification Number: 445316

Hillcrest Healthcare Center

Street Address, City, State, ZIP Code
111 E Pemberton Street
Ashland City, TN 37015

F 262

Continued from page 3

Follow the comprehensive care plan for assistance with meals or applying a body alarm for 2 of 16 (Residents #3 and 13) sampled residents.

F 262

All nurses, caregivers and dietary staff will be in-service to provide the appropriate level of assistance with dining as ordered. The Unit Manager or Team Leader will randomly and periodically monitor diet orders to ensure continued compliance. If any issues of non-compliance are found they will be corrected immediately and referred to the QA Committee for corrective action.

c) The Dietary Manager, Unit Manager or Team Leader will report all results of monitoring audits to the QA Committee who will review and implement corrective measures as necessary.

2) Body alarm - Resident #13

a) Upon notification the body alarm for resident #13 was obtained and placed on the resident.

b) All residents with orders for body alarms have been assessed and will have a body alarm in place as ordered.

c) All nurses and caregivers will be in-serviced to provide body alarms as ordered. The Team Leader will randomly and periodically monitor body alarms to ensure continued compliance. If any issues of non-compliance are found they will be corrected immediately and referred to the QA Committee for corrective action.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

HILLCREST HEALTHCARE CENTER

**SUMMARY STATEMENT OF DEFICIENCIES**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

<table>
<thead>
<tr>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F 282</td>
<td>Continued From page 4 2/15/11 at 7:45 PM, Nurse #7 confirmed Resident #13 had a physician's order and was care planned for a body alarm. Nurse #7 also confirmed there was no body alarm on Resident #13.</td>
<td></td>
</tr>
<tr>
<td>F 309</td>
<td>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</td>
<td></td>
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</table>

**STREET ADDRESS, CITY, STATE, ZIP CODE**

111 PEMBERTON STREET
ASHLAND CITY, TN 37015

**DATE SURVEY COMPLETED**

02/16/2011

---

**F 282**

*d)* The Unit Manager or Team Leader will report all results of monitoring audits to the QA Committee who will review and implement corrective measures as necessary.

**F 309**

**F 309**

*a)* Upon notification Resident #3's diet orders were verified per physician order in chart and a staff member placed with resident for stand by assist with meals.

**B)* All resident physician diet orders will be compared with dietary diet orders to ensure accuracy of tray cards by the Dietary Manager, Unit Manager or Team Leader.

**C)* All nurses, caregivers and dietary staff will be in-serviced to provide the appropriate level of assistance with dining as ordered. The Unit Manager or Team Leader will randomly and periodically monitor diet orders to ensure continued compliance. If any issues of non-compliance are found they will be corrected immediately and referred to the QA Committee for corrective action.

**D)* The Dietary Manager, Unit Manager or Team Leader will report all results of monitoring audits to the QA Committee who will review and implement corrective measures as necessary.

---

Observations in Resident #3's room on 2/15/11 at 12:15 PM and on 2/15/11 at 5:40 PM, Certified Nursing Assistant (CNA) #2 served Resident #3 her meal. CNA #2 did not assist Resident #3 with
**Hillcrest Healthcare Center**

<table>
<thead>
<tr>
<th>ID</th>
<th>GROUP</th>
<th>DESCRIPTION</th>
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<tr>
<td>F 309</td>
<td>Continued from page 5</td>
<td>the meal as ordered.</td>
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<tr>
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<td></td>
<td>During an interview at the nurse’s station on 2/15/11 at 6:10 PM, Nurse #7 was asked if Resident #3 was to be assisted with her meals. Nurse #7 stated, “...They are to assist feed as scheduled.”</td>
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<td></td>
<td>2.</td>
<td>Medical record review for Resident #5 documented an admission date of 8/30/09 with diagnoses of Chronic Obstructive Pulmonary Disease, Anxiety, Chronic Pain, Major Depression and Failure to Thrive. Review of a physician’s order dated 1/28/11 documented, “...BODY ALARM TO WHEELCHAIR WHEN OUT OF BED FOR SAFETY...” Review of the comprehensive care plan reviewed 2/21/11 documented, “...Body alarm to W/C [wheelchair] when OOB [out of bed].”</td>
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<tr>
<td></td>
<td></td>
<td>Observations in Resident #5’s room on 2/14/11 at 4:15 PM and on 2/15/11 at 10:05 AM, 12:00 PM and 2:45 PM, revealed Resident #5 seated in a wheelchair with a body alarm hanging on the back of the wheelchair. The body alarm was not clipped to Resident #5.</td>
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<tr>
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<td></td>
<td>During an interview in Resident #5’s room on 2/15/11 at 2:45 PM, CNA #6 looked at the body alarm on Resident #5’s wheelchair and stated, “It’s [body alarm] not clipped to her shirt. It wouldn’t work like that.”</td>
</tr>
<tr>
<td>F 315</td>
<td>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</td>
<td>Based on the resident’s comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the</td>
</tr>
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<td>F 315</td>
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</tbody>
</table>
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLA Identification Number:** 445516

**Multiple Constructions:**

**Date Survey Completed:** 02/16/2011

**Name of Provider or Supplier:** Hillcrest Healthcare Center

**Address:**

111 E Pemberton Street
ASHLAND, TN 37102

### Summary Statement of Deficiencies

**Prefix Tag:** F315

- Continued from page 6
- Resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

- **This REQUIREMENT is not met as evidenced by:**
  - Based on review of the "Sorensen and Luckmann's Basic Nursing A Psychophysiological Approach", medical record review, observation, and interview, it was determined the facility failed to provide appropriate treatment and care of a Foley catheter by allowing the Foley catheter tubing to touch the floor for 1 of 1 (Resident #10) sampled resident with indwelling Foley catheter with a history of a urinary tract infection (UTI).

- **The findings included:**
  - Review of "Sorensen and Luckmann's Basic Nursing A Psychophysiological Approach" third edition, page 1187, documented "...the bag [Foley catheter bag] and tubing must never touch the floor... These actions increase the chances for bacteria in the drainage bag to ascend the tubing and possibly to enter the bladder. Bacteria in the drainage bag can lead to UTI and subsequent increased mucus production..."

  - Medical record review for Resident #10 documented an admission date of 9/24/04 with diagnoses of Multiple Sclerosis, Acute Renal Failure, Depression, Hypertension, Parkinson's Disease and Neurogenic Bladder. Review of the physician's recertification orders dated 12/8/11 documented, "...07/28/10: FOLEY CATH"

### Provider's Plan of Correction

**Prefix Tag:** F315

1. All residents with Foley catheters will have their tubing positioned to keep it off the floor.
2. All caregivers will be instructed to position Foley catheter tubing to keep it off of floor. The Team Leader will randomly and periodically monitor Foley catheter tubing to ensure continued compliance. If any issues of non-compliance are found they will be corrected immediately and referred to the QA Committee for corrective action.
3. The Team Leader will report all results of monitoring audits to the QA Committee who will review and implement corrective measures as necessary.
Continued From page 7
[catheter] TO BEDSIDE DRAIN..." Review of a laboratory report results dated 11/8/10 documented Resident #10 had Escherichia coli in her urine.

Observations in Resident #10's room on 2/15/11 at 9:13 AM, revealed Resident #10 seated in a wheelchair (w/o) with a Foley catheter in a privacy bag underneath her wheelchair. The catheter tubing was laying on the floor under the wheelchair.

Observations in the dining room on 2/15/11 at 10:00 AM and on 2/16/11 at 8:20 AM, revealed Resident #10 seated in a w/o with the Foley catheter tubing laying on the floor underneath her chair.

During an interview in the staff development office on 2/16/11 at 10:35 AM, the Director of Nursing (DON) was asked if the Foley catheter tubing should ever be on the floor. The DON stated, "...No, never."

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 service to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

This REQUIREMENT is not met as evidenced by:
Based on policy review, observation and...
**HILLCREST HEALTHCARE CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
111 E PEMBERTON STREET
ASHLAND CITY, TN 37015

<table>
<thead>
<tr>
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<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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</table>
| F 322         | Continued From page 8 interview, it was determined the facility failed to ensure staff followed the procedure for checking placement of the Percutaneous Endoscopic Gastrostomy (PEG) tube 1 of 2 (Resident #4) sampled residents observed during medication administration. The findings included:

Review of the facility's "Enteral Nutrition Therapy, Bolus Gravity/Pump" policy documented, "...Assessment guidelines may include, but are not limited to... 3) Amount of residual noted 4) Placement verification... Assessment 5) ...check position/placement of the tube, and attach barrel of syringes to the end of the tubing... 17) a) Attach 50 to 60 cc [cubic centimeters] syringe containing approximately 10cc air... b) Auscultate the abdomen (approximately 3 inches below the sternum) while injecting the air from the syringe into the tubing. c) Listen for "whooshing" sound to check placement of the tube in the stomach d) Pull back gentle on the syringe to aspirate stomach content... f) If there is more than 100cc of stomach content, withhold medication and notify the physician."

Observations in Resident #4's room on 2/15/11 at 7:25 PM, Nurse #5 did not auscultate to check Resident #4's PEG tube placement or check Resident #4's residual prior to administering the flush or medications.

During an interview on the E hall on 2/15/11 at 7:40 PM, Nurse #5 stated "...I forget to check those [placement and residual], but I know her [Resident #4], when she has too much [residual] she will spit up..." | F 322 | 3) All nurses will be in-services on placement and checking residual for all residents with g-tubes. Each nurse will be observed to ensure they follow proper procedures for administering medications via PEG tube and will be checked off on a skills checklist. The Unit Manager will randomly and periodically monitor g-tube care to ensure continued compliance. If any issues of non-compliance are found they will be corrected immediately and referred to the QA Committee for corrective action.

4) The Unit Manager will report all results of monitoring audits to the QA Committee who will review and implement corrective measures as necessary. | 2/16/2011 |
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</table>
| F322 | Continued From page 9  
During an interview in the staff development room on 2/16/11 at 10:36 AM, the Director of Nursing stated, "...I would expect the nurse to check for auscultation [PEG tube placement] and residual..." |
| F323 | Free of Accident Hazards/SuperVision/Devices  
The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. |

This REQUIREMENT is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to ensure the environment was free of accident hazards such as cracked formica and splintered wood at the nurses' station during all three days (2/14/11, 2/16/11 and 2/16/11) of the survey.  
The findings included:  
Observations of the nurses' station on 2/14/11 at 4:00 PM, on 2/16/11 at 10:55 AM and on 2/16/11 at 2:20 PM, revealed cracked formica on the countertop and splintered wood on the wall and entry gate.  
During an interview at the nurses station on 2/16/11 at 2:20 PM, the Maintenance Supervisor stated, "I have work orders that staff can fill out or they can tell me verbally... I'm waiting for money approval [for repairs] for the nurses' station." |
### Statement of Deficiencies and Plan of Correction

#### Summary Statement of Deficiencies

**ID PREFIX TAG**: F 332  SS- E  
**Description**: 483.25(m)(1) Free of Medication Error Rates of 5% or More

- The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:
- Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure 4 of 6 (Nurses #2, 3, 5 and 6) nurses administered medications without a medication error rate of less than 5 percent (%). A total of 7 errors were observed out of 41 opportunities for error resulting in a medication error rate of 17.07%.

The findings included:

1. Review of the facility's "Administering Medications through a Metered Dose Inhaler" policy documented, "...3) Allow at least one (1) minute between inhalations of the same medication... 10) Rinse mouth after administration of steroid inhalers..."

Medical record review for Random Resident (RR) #2 documented an admission date of 3/13/08 with diagnoses of Pneumonia, Difficulty in Walking, Dementia, Dysphagia, Atrial Fibrillation, Muscle Weakness and Mitral Valve Insufficiency. Review of the physician's order dated for 1/28/11 documented, "Combivent Inhaled 2 PUFFS THREE TIMES DAILY @ [at] 10 AM, 6 PM and 11 PM... RESTASI...0.05% DROPERETTE 1 EACH EYE TWICE DAILY 1000 [10:00 AM] 2000 [6:00 PM]..." Review of the physician's order dated 2/1/11 documented, "Order clarification..."

#### Provider's Plan of Correction

**ID PREFIX TAG**: F 332  SS- E  
**Description**: F 332

**Requirement**: 3/16/11

- Upon notification of inhaler administration errors for residents #2, 3, 5 and 6 the nurses properly administered inhaler treatments.
- All residents with orders for inhalers will have their inhaler administered properly.
- To reinforce the nurses' knowledge regarding correct administration of medications, an in-service will be conducted by the licensed pharmacist on a routine basis. To reinforce the nurses' knowledge regarding correct administration of medications, an in-service will be conducted by the licensed pharmacist and/or pharmacy representative on proper administration of medications, placing emphasis on administering inhalants. In addition, each nurse will be observed by a licensed pharmacist and/or pharmacy representative or registered nurse to determine proper compliance with medication administration. In addition, the Unit Manager will randomly and periodically monitor inhaler administration to ensure continued compliance. If any issues of non-compliance are found they will be corrected immediately and referred to the QA Committee for corrective action.
<table>
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<th>F 332</th>
<th>Continued from page 11</th>
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<tbody>
<tr>
<td></td>
<td>change all 0930 [3:30 AM] meds [medications] to 1000 [10:00 AM] change all 2130 [9:30 PM] meds to 2200 [10:00 PM, &quot;]</td>
</tr>
<tr>
<td></td>
<td>Observations in RR #2's room on 2/14/11 at 3:35 PM, Nurse #2 gave Combivent inhaler to RR #2. Nurse did not instruct RR #2 to wait one minute between puffs. The failure to wait one minute between puffs resulted in medication error #1.</td>
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<td>Observations in RR #2's room on 2/14/11 at 3:45 PM, Nurse #2 administered Restasis eye drops to RR #2. Nurse #2 gave the medication 2 hours and 16 minutes early. The failure to give the medication at the correct time resulted in medication error #2.</td>
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<td></td>
<td>During an interview in the staff development office on 2/16/11 at 10:30 AM, the Director of Nurses (DON) confirmed that it was the night nurses responsibility to make sure that the most recent physician's orders and the Medication Administration Records were correct.</td>
</tr>
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<td>2. Medical record review for RR #3 documented an admission date of 8/3/09 with diagnoses of Dementia, Cerebrovascular Disease, Hemiplegia, Hypertension. Review of the physician's orders dated for 1/28/11 documented, &quot;Ger-Vita Liquid 5 mL [milliliters] BY MOUTH TWICE DAILY.&quot;</td>
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<td>Observations in RR #3's room on 2/14/11 at 4:05 PM, revealed Nurse #3 gave multivitamin mineral supplement 15 ml. The failure to give 5 ml resulted in medication error #3.</td>
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<td>3. Medical record review for Resident #5 documented an admission date of 9/30/09 with</td>
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<tr>
<td>F 332</td>
<td>d) The Unit Manager will report all results of monitoring audits to the QA Committee who will review and implement corrective measures as necessary.</td>
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<tr>
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<td>Item 2.</td>
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<tr>
<td></td>
<td>a) Medications for residents #2 and #3 will be administered in accordance with physician orders.</td>
</tr>
<tr>
<td></td>
<td>b) Medications for all residents will be administered in accordance with physician orders.</td>
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</table>
|       | c) It is the practice of the facility to have medication pass observation conducted by the consulting pharmacist on a routine basis. To reinforce the nurses' knowledge regarding correct timing of administration of medications, an In-service will be conducted by the licensed pharmacist and/or pharmacy representative on proper administration of medications, placing emphasis on timeliness of medications. In addition, each nurse will be observed by a licensed pharmacist and/or pharmacy representative or registered nurse to determine proper compliance with medication administration. In addition, the Unit Manager will randomly and periodically monitor timing of medication administration to ensure continued compliance. If any issues of non-
F 332. Continued From page 12

diagnoses of Urinary Tract Infection, Chronic Airway Obstruction, Cardiomyopathy, Obstructive Chronic Bronchitis, Depressive Disorder and Anemia. Review of a physician’s order dated 1/25/11 documented, "CLONAZEPAM 0.5 MG [milligram] 1 TAB [tablet] BY MOUTH TWICE DAILY... 0830 [08:30 AM], 2200 [10:00 PM]"
...KADIAN SR [sustained release] 10 MG CAP [capsule] SR [sustained release]... 1 CAP BY MOUTH EVERY 12 HOURS... 0830, 2200...
RISPERIDONE 0.25 MG TABLET 1 TAB BY MOUTH TWICE DAILY 0830, 2200..."

Observations in Resident #5’s room on 2/15/11 at 7:35 PM. Nurse #6 administered Clonazepam 0.05 tablet, Kadian SR 10 mg capsule and Risperidone 0.25 mg tablet. Nurse #5 gave the medications 2 hours and 55 minutes early. The failure to give the medications at the correct time resulted in medication errors #4, 5 and 6.

4. Medical record review for RR #8 documented an admission date of 2/22/08 with diagnoses of Chronic Airway Obstruction, Depressive Disorder, Anxiety, Anemia, Mitral Valve Disorder, Osteoarthritis, Paralysis Agitans, Chronic Pain and Congestive Heart Failure. Review of a physician’s order dated 1/28/11 documented, "ADVIR DISKUS 250-250 DISK... INHALE 1 PUFF BY MOUTH TWICE DAILY-RINSE MOUTH WITH WATER AFTER ADMINISTRATION-DO NOT SWALLOW..."

Observations in RR #8’s room on 2/15/11 at 7:20 PM. revealed Nurse #6 assisted RR #8 with the Advair Diskus. Nurse #6 did not instruct the RR #8 to rinse his mouth out after use. The failure to rinse his mouth out resulted in medication error #7.
During an interview on the A hall on 2/16/11 at 7:55 PM, Nurse #6 stated, "Probably should have [said resident to rinse] but I don't usually work this hall..."

Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.

The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

This REQUIREMENT is not met as evidenced by:

Based on review of the nursing home licensing checklist form and interview, it was determined the facility failed to ensure there was a Registered Nurse (RN), other than the Director of Nursing, on duty for 2 of 14 (2/10/11 and 2/11/11) days from January 25, 2011 through February 11, 2011. The Director of Nursing may serve as the RN only when the facility has an average daily occupancy of 60 or fewer residents.

The findings included:

Review of the licensure staffing requirement section of the nursing home licensing checklist

1) It is the practice of the facility to have RN services for at least 8 consecutive hours a day, 7 days a week. The two days the facility was without RN coverage was due to a short lapse between the departure of two staff RNs and the start of employment for another RN. The Director of Nursing was on site, on call and available during those two days.

2) An RN has been hired and the facility continues to meet the regulations for RN coverage.

3) The Director of Nursing will monitor the nursing schedule to ensure at least 8 hours of RN coverage are scheduled and worked. In the event of illness or other situation when a RN is not able to work, the Director of Nursing and Administrator will ensure RN Coverage.

4) The Director of Nursing will report all results of monitoring audits to the Administrator and QA Committee who will review and implement corrective measures as necessary.
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<tr>
<th>ID</th>
<th>PREMIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PROVIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tbody>
<tr>
<td>F 354</td>
<td>Continued From page 14 revealed there was no RN on duty for 2/10/11 and 2/11/11. The facility's census for 2/10/11 was 72 and 2/11/10 was 71. During an interview in the staff development office on 2/15/11 at 4:20 PM, the Administrator stated, &quot;...We don't have the RN for two days during this period...&quot;</td>
<td>F 354</td>
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<tr>
<td>F 371</td>
<td>483.35(F) FOOD PRODUCE, STORE/REPLACE/SERVE - SANITARY</td>
<td>F 371</td>
<td>F371</td>
<td>Item 1 - Date of completion March 2, 2011</td>
<td></td>
</tr>
</tbody>
</table>

a. Hair and beard restraints were ordered immediately and are being used as appropriate for all facility staff.
b. All employees will wear hair and beard restraints as appropriate when entering the kitchen. The kitchen staff will deny entry to anyone who is not in compliance.
c. All facility staff will be re-serviced on proper procedures for hair and beard restraint in the kitchen. The Dietary Manager will document all staff who fail to comply with hairnet rules and report them to administrator. In addition, if issues of non-compliance are found they will be corrected immediately and referred to the QA Committee for corrective action.
d. The Dietary Manager will report all results of monitoring audits to the QA Committee who will review and implement corrective measures as necessary.

The findings included:

1. Review of the facility's "PERSONAL
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<td></td>
<td>F-371</td>
<td></td>
<td>Continued From page 15</td>
<td></td>
<td>F-371</td>
<td></td>
<td>a. The dish machine was cycled until the proper temperatures were attained.</td>
<td>02/16/2011</td>
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<td></td>
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<td></td>
<td>HYGIENE policy documented, &quot;...3.e... a hairnet must be worn... The entire hair must be covered...</td>
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<td></td>
<td>b. The hot water line servicing the dish machine will be repaired or replaced.</td>
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<td></td>
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<td></td>
<td>3.c. Beards or any body hair that may be exposed...must be covered...&quot;</td>
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<td></td>
<td>c. The Dietary Manager will in-service all dietary staff on dish machine temperature requirements including maintaining a minimum temperature of 120 degrees F during the wash and final rinse cycles. In addition, the Dietary Manager or staff will maintain a temperature log to be completed 3 times daily for one week to assure the dish machine reaches a minimum of 120 degrees F throughout the day. If temperatures are maintained at 120 degrees F consistently for one week the temperature log entries will be reduced to once per day. If issues of non-compliance are found they will be corrected immediately and referred to the QA Committee for corrective action.</td>
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<td>Observations in the kitchen on 2/14/11 at 10:20 AM and 2/16/11 at 9:35 AM, the Dietary Manager (DM) and Assistant Dietary Manager (ADM) were working in the food preparation area with their beards not covered.</td>
<td></td>
<td></td>
<td></td>
<td>d. The Dietary Manager will report all results of monitoring audits to the QA Committee who will review and implement corrective measures as necessary.</td>
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<td>Observations in the kitchen on 2/14/11 at 2:25 PM, the Assistant Activities Coordinator was in the kitchen without her entire hair covered.</td>
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<td></td>
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<td>Observations in the kitchen on 2/16/11 at 6:50 AM, the DM working in the food preparation area with his beard not covered.</td>
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<td>During an interview in the kitchen on 2/16/11 at 9:35 AM, the DM was asked if staff should wear hair coverings. The DM stated, &quot;...yeah we will take care of that...&quot;</td>
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<td>2. Review of the facility's &quot;RECORDING OF DISHMACHINE TEMPERATURES&quot; policy documented, &quot;...Low Temperature Dishmachines Wash Temperature 120-160 degrees Fahrenheit [F].&quot;</td>
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<td>Observations in the kitchen on 2/14/11 at 10:20 AM and 2:25 PM and on 2/15/11 at 9:20 AM, the low temperature dish machine did not reach 120 degrees F.</td>
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</table>
|    |        |     | During an interview in the dish wash room on 2/14/11 at 2:40 PM, the ADM was asked about the temperature readings of the low temperature dish machine. The ADM stated, "...yeah, it is not
During an interview in the dish wash room on 2/18/11 at 8:30 AM, the DM stated, "...the dish washer does not stay 120 degrees..."

3. Review of the facility's "COTS AND PANS -SANITIZING SOLUTION" policy documented, "...3. Allow all items to air dry. Towels should not be used for drying..."

Observations in the kitchen on 2/16/11 at 10:15 AM, dietary staff member (DSM) #1 removed clean bowls from the tray, dried the bowls with a towel and placed the bowls on the storage cart.

During an interview in the kitchen on 2/18/11 at 9:35 AM, the DM was asked about drying the dishes with a towel. The DM stated, "...they [dietary staff] know better..."

4. Review of the facility's "SANITIZER USE CONCENTRATIONS FOR FOOD SERVICE AND FOOD PRODUCTION FACILITIES" policy documented, "...4. Sanitizing cloths should be placed in the sanitizing bucket to be used in sanitizing all work surfaces and equipment."

Observations in the kitchen on 2/14/11 at 2:15 PM, revealed the following:
   a. Wet cloth on preparation table laying next to a cupcake.
   b. Dry cloth on preparation table laying next to a pie.

Observations in the kitchen on 2/18/11 revealed the following:
   a. 10:15 AM, wet cloth on preparation table laying next to the chicken.
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**[X] PROVIDER/SUPPLIER/CLAUS**
**IDENTIFICATION NUMBER:** 445315

**[X] MULTIPLE CONSTRUCTION**
**A. BUILDING**
**D. WINGS**

**[X] DATE SURVEY COMPLETED:** 02/16/2011

**NAME OF PROVIDER OR SUPPLIER:** HILLCREST HEALTHCARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 111 E PEMBERTON STREET
ASHLAND CITY, TN  37015

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<tr>
<td>F 371</td>
<td>Continued From page 17</td>
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<tr>
<td></td>
<td>b. 11:20 AM, dry cloth on preparation table laying next to the food processor while food being prepared.</td>
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<tr>
<td></td>
<td>c. 6:20 PM, wet cloth on preparation table laying next to the pimento cheese. A dry cloth on the preparation table laying next to the muffin pan.</td>
</tr>
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</table>

Observations in the kitchen on 2/16/11 at 10:15 AM, revealed the following:

- A dry cloth near the food on the pastry preparation table.
- A dry cloth near the food and the processor on the main preparation table.
- A third dry cloth at the end of the preparation table.

During an interview in the kitchen on 2/16/11 at 10:15 AM, the DM was asked what would he expect staff to do with cloths that have been used. The DM stated, "...the dish cloths are to be stored in the sanitizer bucket and the dry cloth in the pail..."  

6. Observations in the kitchen on 2/14/11 at 10:20 AM, on 2/15/11 at 8:50 AM and on 2/16/11 at 9:35 AM, revealed the garbage disposal had backed up water and debris in the sink, the pipe underneath the disposal was leaking fluid on the floor and there was a pail under the sink filled with very dark colored, debris filled liquid.

During an interview in the kitchen on 2/14/11 at 2:25 PM, the DM was asked if the garbage disposal was functioning properly. The DM stated, "...garbage disposal is backed up... the pail is full of back up from the garbage disposal..."

6. Review of the facility’s "DAILY CLEANING AND CHECKLIST" policy documented,

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<tr>
<td>F 371</td>
<td>d. The Dietary Manager will report all results of monitoring audits to the QA Committee who will review and implement corrective measures as necessary.</td>
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</tbody>
</table>

Item 5.

a. The garbage disposal malfunctioned the morning of survey and was already in the process of being repaired. It was repaired immediately.

b. The garbage disposal is the only garbage disposal in the facility; however, if other garbage disposals are installed they will be properly maintained to ensure no leaks are present.

c. The Dietary Manager will monitor the sink to ensure there are no additional issues with leaks. If issues of non-compliance are found they will be corrected immediately and referred to the QA Committee for corrective action.

d. The Dietary Manager will report all results of monitoring audits to the QA Committee who will review and implement corrective measures as necessary.

Item 6.

a. The refrigerator and freezer temperature logs will be maintained daily for all refrigerators and freezers in Dietary.

b. Should any additional refrigerators or freezers be installed in Dietary the temperatures will be checked daily.
<table>
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<tr>
<th>F 371</th>
<th>Continued From page 18</th>
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<tbody>
<tr>
<td>&quot;...COOK'S AND AIDES A.M. 1. Check and record freezer/cooler temps [temperatures]....&quot;</td>
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</table>
| Review of the facility's refrigerator and freezer temperature logs on 2/15/11 at 4:00 PM, revealed the refrigerator and freezer log had no temperature logs recorded for 2/10/11, 2/11/11 and 2/12/11. 
| During an Interview in the DM's office on 2/15/11 at 4:00 PM, the DM stated, "They [dietary staff] know they are to do that [record temperatures] daily." |
| 7. Review of the facility's "DAILY CLEANING AND CHECKLIST" policy documented, "...6. Wipe down and sanitize all utility carts... COOK'S AND AIDES P.M... 10. Wipe and sanitize all utility carts... 11. Wipe down hoods and drain grease trap." |
| Observations in the kitchen on 2/14/11 at 2:25 PM, on 2/15/11 at 11:20 AM and on 2/16/11 at 10:15 AM, revealed 5 rolling racks with dried substances and dirt on the base, wheels and shelves. 
| During an interview in the kitchen on 2/16/11 at 10:15 AM, the DM was asked to look at the racks. The DM stated, "...yeah those rolling racks are dirty..." |
| Observations in the kitchen on 2/14/11 at 10:20 AM, on 2/15/11 at 8:50 AM and on 2/16/11 at 9:35 AM, revealed the smooth side of the vent area over the stove had a large amount of while splattered material over the majority of the vent area. |
## DEPARTMENT OF HEALTH AND HUMAN SERVICES
### CENTERS FOR MEDICARE & MEDICAID SERVICES

<table>
<thead>
<tr>
<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
<th>PROVIDER/SUPPLIER IDENTIFICATION NUMBER:</th>
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<tbody>
<tr>
<td>(X) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:</td>
<td>A. BUILDING: 44516</td>
</tr>
<tr>
<td>(X) MULTIPLE CONSTRUCTION</td>
<td>B. WING:</td>
</tr>
<tr>
<td>(X) DATE SURVEY COMPLETED</td>
<td>02/16/2011</td>
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</tbody>
</table>

### NAME OF PROVIDER OR SUPPLIER

HILLCREST HEALTHCARE CENTER

### STREET ADDRESS, CITY, STATE, ZIP CODE

111 E PEMBERTON STREET
ASHLAND CITY, TN 37015

### SUMMARY STATEMENT OF DEFICIENCIES

**F 371** Continued From page 18
During an interview in the kitchen on 2/16/11 at 9:35 AM, the DM was asked about the white material on the vent over the stove. The DM stated, "...yeah I saw that, it looks like something blew up..."

8. Review of the facility's "KITCHEN DEEP CLEANING SCHEDULE" policy documented, "...Clean dust and grease from all vents and ceiling tiles in kitchen."

Observations in the kitchen on 2/14/11 at 10:20 AM, on 2/15/11 at 8:50 AM and on 2/16/11 at 9:35 AM, revealed a moderate amount of black substance on the air flow vent above the food preparation table.

During an interview in the kitchen on 2/16/11 at 9:35 AM, the DM confirmed the air flow vent needed to be cleaned.

8. Observations in the kitchen on 2/15/11 revealed the following:
   a. 11:20 AM, a receptionist brought dirty urns through the clean entrance of the kitchen.
   b. 6:20 PM, Certified Nursing Assistant (CNA) #4 and CNA #7 brought dirty equipment through the clean entrance of the kitchen.
   c. 12:13 PM, RD transported a rolling cart with dirty trays and debris through the clean entrance of the kitchen.

During an interview in the kitchen on 2/16/11 at 10:15 AM, the DM was asked about the large volume of non-dietary staff walking through the kitchen and transporting dirty items through the clean entrance. The DM stated, "...it is a problem [staff entering the clean entrance with dirty items]."

### PROVIDER'S PLAN OF CORRECTION

**F 371**

d. The Dietary Manager will report all results of monitoring audits to the QA Committee who will review and implement corrective measures as necessary.

### Item 8.

a. The vents and ceiling were cleaned immediately.
b. The vents will be removed and cleaned as needed. In addition all ceiling vents will be painted.
c. The Dietary Manager will in-service all dietary staff on cleaning and maintenance of vents and ceiling. The Dietary Manager will monitor the cleaning schedule to ensure vents and ceiling are cleaned as needed. If issues of non-compliance are found they will be corrected immediately and referred to the QA Committee for corrective action.
d. The Dietary Manager will report all results of monitoring audits to the QA Committee who will review and implement corrective measures as necessary.

### Item 9.

a. The individuals transporting dirty trays through the clean entrance were stopped immediately.
b. All dirty trays and debris will be brought into the dish room entrance.
c. All facility staff will be in-service to only bring dirty trays and debris into the kitchen through the clean entrance. The Dietary...
10. Observations in the walk in refrigerator on 2/14/11 at 10:20 AM, on 2/15/11 at 10:15 AM and on 2/16/11 at 10:15 AM, revealed a pool of water near the inner wall and a rusted floor in the walk in refrigerator.

During an interview in the walk in refrigerator on 2/15/11 at 2:46 AM, the DM was asked about the water on the floor. The DM stated, "...yeah, water is standing. See the rusted floor..."

11. Observations in the dish wash room on 2/14/11 at 2:40 PM, DSM #2 was washing dirty dishes, placed the dirty dishes in the low temperature dish machine, proceeded to the clean dishes and removed them from the rack and placed them in the stacker. DSM #2 repeated working from the dirty area to the clean area for three loads without washing her hands.

During an interview in the dish wash room on 2/16/11 at 10:16 AM, the DM was asked when and how staff were to wash their hands. The DM stated, "...I usually have one person doing the dirty dishes and another on the clean side, but we were short handed on Monday... If they need to wash their hands they can place them in the red sanitizer bucket..."

12. Review of the facility's "KITCHEN DEEP CLEANING SCHEDULE" policy documented, "...mop under dish machine area, under work tables, and behind coolers and oven... wipe down walls with sanitizer..."

Observations in the dish wash room on 2/14/11 at 2:25 PM, revealed the floors and lower walls of the room were covered with white and black
who will review and implement corrective measures as necessary.

Item 11.

a. DSM #2 was stopped immediately upon notification and in-serviced on proper cleaning procedures.
b. The Dietary Manager will in-service all dietary staff on proper dish washing techniques. The Dietary Manager will periodically monitor staff compliance with dishwashing policies and procedures and will ensure all dishes are being washed in a sanitary manner. If issues of non-compliance are found they will be corrected immediately and referred to the QA Committee for corrective action.
c. The Dietary Manager will report all results of monitoring audits to the QA Committee who will review and implement corrective measures as necessary.

Item 12.

a. All areas noted were cleaned immediately by the dietary staff.
b. The dietary staff will implement the cleaning of all areas noted in accordance with the Deep Cleaning schedule.
c. The Dietary Manager will in-service the dietary staff on proper cleaning techniques as well as keeping the requirements of the deep cleaning schedule. All tasks on the Deep
### F 371
- **Summary Statement of Deficiencies:**
  - Substances, and pieces of debris. The facing of the door that exited the dish wash room leading to the dining room was rusted and crumbling.
  - During an interview in the dish wash room on 2/15/11 at 10:15 AM, the dietary staff were asked about the frequency and method of cleaning the dish washer room. DSM #3 stated, "...do a clean once or twice a week, no certain day, last cleaned sometime last week..." DSM #4 stated, "...we did not scrub it [dish wash room] last night like we usually do..."
  - During an interview in the dish wash room on 2/16/11 at 10:15 AM, the CM was asked about the appearance of the floor and walls of the room. The CM stated, "...yeah, it [dish wash room] is dirty..."

### F 441
- **408.65 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

---

**Cleaning Schedule:**
- The cleaning schedule will be completed per policy. If issues of non-compliance are found, they will be corrected immediately and referred to the QA Committee for corrective action.
- The Dietary Manager will report all results of monitoring audits to the QA Committee who will review and implement corrective measures as necessary.

**Resident #17**
- (a) Upon notification of no Isolation sign on door, sign obtained and placed on door.
- (b) No other residents are currently on isolation, however, if any other residents are placed on isolation an appropriate sign will be placed on their door.
- (c) All nurses will be in-serviced on proper procedures for placing residents on isolation. The Unit Manager will randomly and periodically monitor residents' rooms in isolation to ensure proper signage is on the door. If any issues of non-compliance are found, they will be corrected immediately and referred to the QA Committee for corrective action.
- (d) The Unit Manager will report all results of monitoring audits to the QA Committee who will review and
F 441 Continued From page 22

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.

(a) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure 4 of 9 nurses (Nurse #1, 3, 5 and 7) nurses and 1 of 7 Certified Nursing Assistants (CNA #2) practiced proper hand washing techniques to prevent the potential spread of infection. The facility failed to post precautions for isolation for 1 of 1 (Resident #17) sampled resident in contact isolation.

The findings included:

1. Review of the facility's "Hand Hygiene" policy documented, "Policy Statement To decrease the risk of the transmission of infection by appropriate hand hygiene... Hand Washing... after going to the restroom, and before eating, performing hand hygiene with both a non-antimicrobial soap and
F-441 Continued From page 23

water.

a. Observations in Random Resident (RR) #1's room on 2/14/11 at 2:05 PM, Nurse #1 washed her hand before administering medications and turned the faucet off with her bare hands.

b. Observations in RR #3's room on 2/16/11 at 3:55 PM, Nurse #3 did not wash her hands before administering medications.

c. Observation in Resident #4's room on 2/15/11 at 7:25 PM, Nurse #5 washed her hands and turned the faucet off with her bare hands.

Observation in Resident #5's room on 2/15/11 at 7:35 PM, Nurse #5 did not wash her hands before administering medications. Nurse #5 administered medications washed her hands and turned the faucet off with her bare hands.

d. Observation in RR #12's room on 2/15/11 at 9:50 AM, Nurse #7 performed a dressing change on RR #12. Nurse #7 did not wash her hands between taking the old dressing off and cleaning RR #12's wound.

Observations in Resident #11's room on 2/15/11 at 10:45 AM, Nurse #7 performed a dressing change on Resident #11. Nurse #7 did not wash her hands between taking the old dressing off and cleaning Resident #11's wound.

e. Observations in room 206 on 12/15/11 at 12:57 PM, CNA #2 placed the lunch meal tray on the overbed table, cranked the head of the bed with his bare hands and then touched a piece of chicken without washing his hands.
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<tr>
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<th>(X5) COMPLETION DATE</th>
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<tr>
<td>F 441</td>
<td>Continued From page 24 Observations in room 206 on 12/15/11 at 5:58 PM, CNA #2 placed the dinner meal tray on the overbed table, cranked the head of the bed with his bare hands and held the grilled cheese sandwich to feed a resident without washing his hands. 2. Medical Record review for Resident #17 documented an admission date of 2/8/11 with diagnoses of Clostridium Difficile (C. Diff), Pneumonia, Chronic Airway Obstruction, Anemia, Esophageal Reflux and Acute Kidney Failure. Observations during the initial tour on 2/14/11 at 10:36 AM, on 2/15/11 at 11:42 AM and 6:43 PM and on 2/16/11 at 8:50 AM, revealed a cart in the hallway outside of room 303 with no posted sign to indicate the purpose of the cart. During an interview at the nurses' station on 2/16/11 at 9:20 AM, Nurse #8 was asked why the cart was outside of Resident #17's room (room 303). Nurse #8 confirmed Resident #17 was infected with C. Diff and was in contact isolation. Nurse #8 stated, &quot;There should be a sign on the door...&quot;</td>
<td>F 441</td>
<td>F 465</td>
<td>3/16/11</td>
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<tr>
<td>F 465</td>
<td>463.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to provide a sanitary</td>
<td>F 465</td>
<td>F 465</td>
<td>3/16/11</td>
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Continued From page 25

environment for resident, staff and the public as evidenced by a dirty fish aquarium in the resident common area for 2 of 3 (2/14/11 and 2/15/11) days of the survey.

The findings included:

Observations in the common area on 2/14/11 at 10:47 AM and on 2/15/11 at 9:00 AM, revealed the fish aquarium to have cloudy, dirty and discolored water.

During an interview in the common area on 2/16/11 at 9:15 AM, Rendent Resident (RR) #18 was asked if she liked to watch the fish in the aquarium. RR #18 stated, "Couldnt see the fish good yesterday [2/15/11] because the water was dirty...I watch them [the fish] every day."

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review, observation and interview, it was determined the facility failed to provide obtain laboratory (lab) tests in a timely manner when ordered by the physician for 1 of 10 (Resident #10) sampled residents.

The findings included:

Review of the facility's "Lab Policy" documented,

procedure will be developed for fish tank maintenance.

2. No other fish tanks are in the facility, however, when the original tank is returned the aquarium will be kept clean.

3. When the fish tank is reinstalled, the revised policy and procedure for keeping the fish tank clean will be implemented. If any issues of non-compliance are found they will be corrected immediately by the Activity Director and referred to the QA Committee for corrective action.

4. The Activity Director will monitor all fish tanks (if any) for any non-compliance and will correct any instances of a dirty tank immediately and will report all results of monitoring audits to the QA Committee who will review and implement corrective measures as necessary.

1) Upon notification the C et S for resident #10 was completed.
2) All residents with orders for UA C et S will be checked to ensure the C et S was completed.
3) The lab system was reviewed and determined to be effective. All nurses will be in-serviced on lab policies and procedures to include C et S procurement. The Unit Manager will randomly and periodically monitor lab records to ensure C et S are completed as ordered. If any issues of non-
**HILLCREST HEALTHCARE CENTER**

<table>
<thead>
<tr>
<th>ID PREP IX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLIANCE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 502</td>
<td>compliance are found they will be corrected immediately and referred to the QA Committee for corrective action, 4) The Unit Manager will report all results of monitoring audits to the QA Committee who will review and implement corrective measures as necessary</td>
<td></td>
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</tbody>
</table>

...Continued from page 26

"...This facility will notify the Resident's Physician of abnormal lab results in a timely manner. ...Protocol — ...2. Abnormal labs are to be called to the physician the same day they are received for further orders. (Do not fax abnormal labs. Call the doctor.) ...Documentation may include, but is not limited to ...2. Document notification of physician and orders received in Nursing Notes...."


Observations in Resident #10's room on 2/15/11 at 9:13 AM, revealed Resident #10 seated in a wheelchair (w/c) with a Foley catheter in a privacy bag underneath her wheelchair. The catheter tubing was laying on the floor under the wheelchair.
**F 502** Continued From page 27

Observations in the dining room on 2/15/11 at 10:00 AM and on 2/16/11 at 8:20 AM, revealed Resident #10 seated in a w/c with the Foley catheter tubing laying on the floor underneath her chair.

During an interview at the nurses’ station on 2/15/11 at 7:45 PM, the Director of Nursing (DON) was asked for the C&S results from the 10/22/10 UA. The DON came to the surveyor in the front lobby on 2/15/11 at 8:00 PM, and stated "...we usually write a telephone order [when the doctor orders something on a lab result],..." The DON was asked if there was documentation that the order was written. The DON stated, "...No...not that I see..."

During an interview at the nurses’ station on 2/16/11 at 8:30 AM, Nurse #7 came to the surveyor about the missing C&S results from 10/22/10. Nurse #7 stated, "...we normally write an order..." Nurse #9 (who was with Nurse #7) stated, "...that’s where I screwed up...I could have documented better..." Nurse #7 stated, "...we screwed up...I'll just be honest...need a better tracking system [for labs]."

**F 614**

Records - Complete/Accurate/Accessible

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematized.

The clinical record must contain sufficient information to identify the resident; a record of the

1. The MVI was given to resident #4 as ordered.
2. All residents with MVI order changes will be reviewed to ensure the order is being administered as written.
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>PREM Tag</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (TEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 514</td>
<td></td>
<td>Continued From page 28 resident’s assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to ensure medical records were maintained accurately and completely for 1 of 18 (Resident #4) sampled residents. The findings included: Medical record review for Resident #4 documented an admission date of 6/17/05 with diagnoses of Hypematemesis, Hypokalemia, History of Urinary Tract Infection, Mental Retardation, Colostomy, Constipation, Dysphagia, Cerebral Palsy, Psychosis, Quadraplegia and Tachycardia. Review of a physician’s telephone order dated 1/27/11 documented, “Change Gerivite to Multivitamin Liquid 15 cc [cubic centimeters] PT [per tube] Q [every] day.” The physician’s recertification orders dated 1/28/11 did not reflect this order change. During an interview at the nurse’s station on 2/16/11 at 12:10 PM, the unit manager reviewed Resident #4’s chart. The unit manager stated, “MVI [multivitamin] change not reflected on POF [physician order form] still has Gevrebain on February POF...”</td>
</tr>
<tr>
<td>F 514</td>
<td></td>
<td>3) When the order was received the order was placed on the MAR and given as ordered. All nurses will be in-serviced on physician order transcription. MVI orders will be monitored randomly and periodically by the Unit Manager. If any issues of non-compliance are found they will be corrected immediately and referred to the QA Committee for corrective action. 4) The Unit Manager will report all results of monitoring audits to the QA Committee who will review and implement corrective measures as necessary.</td>
</tr>
</tbody>
</table>