**Plan of Correction for Crestview Health and Rehabilitation**  
Survey 02-22-2011

This Plan of Correction (POC) has been developed in compliance with State and Federal Regulation. This plan affirms Crestview Health and Rehabilitation's intent and allegation of compliance with those regulations. This POC does not constitute an admission or concession of either accuracy or factual allegation made in, or existence or scope of significance, of any cited deficiency.

**F 221 SS=D**  
Right to be free from physical restraints  
The facility will respect the resident's right to be free from physical restraint and complete a restraint assessment.

**Corrective Action for Resident Cited**  
Restraint assessment performed & documented for Resident #17 on 2/24/2011 as required.

**Identification Other Residents**  
All residents with restraints have the potential to be affected by the deficient practice. All residents are currently being reviewed to ensure compliance.
Measure Put in Place or System Changes

~Restraint Consent Form modified to include a checklist of procedural steps to be completed before implementing device.

~Team Leader will present signed Restraint Consent form, Physician's Order, Restraint Assessment, and substantiating Nurse's Notes to DON/ADON for review of proposed device.

~Educational presentation r/t Restraint policies/procedures and corrective plan to all clinical staff with attendance log to be provided by Nurse Educator and/or DON/ADON.

~In addition to monthly restraint reassessments, Residents requiring use of restraint devices will be addressed and reviewed regarding effectiveness and potential for restraint reduction during Patient at Risk (PAR) meetings by Team Leaders, DON/ADON, Social Services and MDS Coordinator.

~All results will be reported monthly to QI committee.

Monitoring Corrective Action

~Compliance will be monitored and maintained by all members of the interdisciplinary team (Team Leaders, Nurse Educator, MDS Coordinators, Social Services, Wound Care/Infection Control, & DON/ADON). Any aberrances are reported to the QI Committee monthly. Interventions are developed and appropriate actions taken.

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The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interviews, it was determined the facility failed to revise the comprehensive care plan for interventions for emergency bleeding, antipsychotics or pain for 5 of 17 (Residents #1, 3, 4, 9 and 13) sampled residents.

The findings included:

1. Medical record review for Resident #1 documented an admission date of 4/13/06 with diagnoses of Major Depressive Disorder, Generalized Anxiety Disorder, Sepsis, Chronic Kidney Disease, Cellulitis, Hypothyroidism and Gout. Review of a physician's order dated 2/8/11

F 280 SS=E
RIGHT TO PARTICIPATE PLANNING CARE – REVISE CP

The facility will revise and maintain comprehensive care plans with interventions related to residents with behaviors and/or on antipsychotics and emergency bleeding as it pertains to residents receiving renal dialysis.

Corrective Action for Resident Cited
– Actions to ensure the Plans of Care will address behavior or absence of behavior for residents receiving treatment with antipsychotic medication carried out immediately for resident #3, 4, 9.
– Plans of Care will address emergency bleeding related to use of A/V shunts and other access portals for hemodialysis for resident #1 and 13.

Identification Other Residents
– All plans of care were reviewed in regard to behavior and/or antipsychotic meds and emergency bleeding for residents identified to be potentially affected and clarified/revised to meet requirements of F 280

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Continued From page 2
documented, "...dialysis M [Monday] W [Wednesday] F [Friday]..." Review of the comprehensive care plan dated 12/23/10 did not include interventions for emergency bleeding from the dialysis shunt site.

During an interview at the first floor nurses station on 2/24/11 at 8:45 AM, Nurse #5 was asked if Resident #1's care plan had interventions for emergency bleeding. Nurse #5 stated "No, it doesn't say what to do if [shunt site] bleeds."

2. Medical record review for Resident #3 documented an admission date of 5/11/07 with diagnoses of Dysphagia, Systemic Inflammatory Process, Hemiplegia, Anxiety Disorder and Depression. Review of physician orders dated 1/31/11 documented, "...Celexa 15 milligrams [mgs] Bid [two times daily] and Klonopin 0.5 mgs Bid..." Review of the comprehensive care plan dated 12/23/10 did not address antipsychotic medications.

During an interview in the Minimum Data Set (MDS) office on 2/24/11 at 1:25 PM, Nurse #5 stated, "If they haven't exhibited any behaviors, after six months I take it [behaviors / antipsychotic medications] off the care plan."

3. Medical record review for Resident #4 documented an admission date of 11/6/09 with diagnoses of Organic Brain Syndrome, Chronic Airway Obstruction and Senile Dementia. Review of physician's orders dated 2/2/11 documented, "...Citalopram 20 mg daily and Risperdal one mg Bid..." Review of the comprehensive care plan dated 12/1/10 did not address antipsychotic medications.

Measure Put in Place or System Changes
~Plans of Care will be reviewed in weekly meeting by MDS coordinator and the rest of the interdisciplinary team to ensure comprehensive care plan interventions pertaining to behaviors/antipsychotic medications, and emergency bleeding not renal dialysis are maintained on current residents as well as future admissions.
~Plans of Care will be also reviewed weekly by interdisciplinary team with facilities Psychiatric Nurse Practitioner to aid in providing accurate and comprehensive plans of care pertaining to behaviors/antipsychotic medications.
~Educational presentations, attendance records, audits, and competency documentation will be completed and maintained by the Nurse Educator.

Monitoring Corrective Action
~Compliance will be monitored and maintained by all members of the interdisciplinary team (Team Leaders, Nurse Educator, MDS Coordinators, & DON/ADON).
~All results will be reported monthly to QI committee.
F 280 Continued From page 3

During an interview in the MDS office on 2/24/11 at 1:25 PM, Nurse #5 stated, "If they haven't exhibited any behaviors, after six months I take it [behaviors / antipsychotic medications] off the care plan. He hasn't had any behaviors for awhile."

4. Medical record review for Resident #9 documented on admission date of 9/17/10 with diagnoses of Senile Dementia with Delusional Features, Osteoarthritic, Organic Brain Syndrome and Anxiety. Review of the "Progress Note - Psychiatric" dated 1/24/11 documented, "...CURRENT PSYCHOTROPIC MEDICATIONS ...Risperdal 0.5mg po bid... Xanax 0.25 mg po tid [three times a day] pm [as needed]...

Review of the comprehensive care plan reviewed 12/23/10 did not address antipsychotic medications.

5. Medical record review for Resident #13 documented an admission date of 1/27/11 with diagnoses of End Stage Renal Disease, Diabetes Mellitus Type II, Dementia and Hypertension. Review of a physician's order dated 2/3/11 documented, "...Dialysis MWF weekly...

Review of the comprehensive care plan did not include interventions for emergency bleeding.

During an interview in the Assistant Director of Nursing's office on 2/24/11 at 1:45 PM, Nurse #5 stated, "No, there is no care plan for bleeding. Just to monitor [for bleeding]."

F 282 SS=D 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER 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.

F 282 SS=D SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

Services provided or arranged by the facility will be provided by qualified persons and will reflect each resident's written plan of care.

Facility will follow plan of care for documenting pre and post dialysis weights as well as for the use of incontinence products.

Corrective Action for Resident Cited

~Complete records of pre and post dialysis weights were requested from dialysis clinic for dates in question to be appended to facility's record for Resident #1.
~Education provided to CNAs related to application of incontinence products and following the written plan of care.

Identification Other Residents

~All residents receiving dialysis have the potential to be affected by the deficient practice r/t pre and post dialysis weights and are being reviewed to verify that pre and post weights are monitored and documented as ordered.
~All residents have the potential to be affected by the deficient practice r/t application of incontinence products. All residents currently being reviewed to ensure compliance.
~Care plans will be updated to state Incontinent products (i.e. pull-ups/protective pads/briefs) will be provided as appropriate.
Crestview Health and Rehabilitation

Measure Put in Place or System Changes
~Educational presentation to all clinical staff
  with attendance log will be provided by
  Nurse Educator and/or DON/ADON
  regarding purpose and use of the plan of care.
  ~Dialysis Communication Forms/Log will be
  provided and maintained at nurses stations to
  assist in maintaining complete records of
  required data.
  ~Upon return from dialysis, Team Leader
  and/or Medication Manager will document
  pre and post weights via dialysis
  communication sheet as per plan of care &
  contact dialysis clinic to obtain required data
  if communication sheet is not returned or
  returned incomplete.
  ~Nurse Educator and/or ADON will conduct
  competency evaluations on all CNAs with
  concentrated attention on deficient areas and
  provide 1:1 education in areas where
  weakness is demonstrated.
  ~All results will be reported monthly to QI
  committee Monitoring Corrective Action
  ~Restorative RN will review documentation
  for compliance with weight documentation
  and report those findings in Morning Clinical
  Meeting twice weekly x 4 weeks, then once
  weekly x 4 weeks, then monthly x 3 months.
  ~Weights of residents receiving dialysis will
  be reviewed by all members of the
  interdisciplinary team at weekly Patient at
  Risk (PAR) meeting to monitor compliance.
  ~Compliance rounds will be performed daily
  by Team Leaders and/or Nurse Educator on
  random residents utilizing incontinence
  products.
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFIENCIES (each deficiency must be preceded by full regulatory or LSC identifying information)</th>
<th>PROVIDER'S PLAN OF CORRECTION (each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>ID</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 282</td>
<td>Continued From page 5  1/21/11, 1/24/11, 1/28/11, 1/31/11, 2/2/11, 2/7/11, 2/11/11 and 2/16/11. The nurses notes had no documented post dialysis weight on 2/21/11.</td>
<td>F 282</td>
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<td>F 309 SS=D</td>
<td>483.25 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>F 309</td>
<td>02/24/2011</td>
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Corrective Action for Resident Cited
~ Education provided to CNAs re't referring to the written plan of care for ordered devices/medical.  
~Upon follow-up assessment, knee-high anti-embolus stocking found to be inappropriate for sampled resident (#1) and subsequently discontinued.

Identification Other Residents
~ For residents identified to be potentially affected, plans of care were reviewed to assure orders were noted, implemented and provided care reflects plan in regard to anti-embolus/ thrombolytic devices.

Measure Put in Place or System Changes
~ Educational presentation to all clinical staff with attendance log will be conducted by Nurse Educator and/or DON/ADON regarding purpose and use of the plan of care, and following physician's orders  
~Nurse Educator and/or ADON will conduct competency evaluations on all CNAs with concentrated attention on deficient areas and provide 1:1 education/disciplinary action in areas where weakness is demonstrated.
**F 309**

Continued From page 6

Observations in the 2nd floor day room on 2/22/11 at 2:00 PM, revealed Resident #1 seated in a wheelchair with no TED hose on as ordered.

Observations in Resident #1's room on 2/23/11 at 6:50 AM and on 2/24/11 at 7:20 AM, revealed Resident #1 lying flat in bed with no TED hose on as ordered.

During an interview in Resident #1's room on 2/24/11 at 7:20 AM, Resident #1 was asked about the TED hose. Resident #1 stated, "I used to wear them [TED hose], but I don't have them anymore."

During an interview in Resident #1's room on 2/24/11 at 7:50 AM, Certified Nursing Assistant #1 checked Resident #1 and stated, "I don't see them [TED hose]."

**F 322**

483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS

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 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, medical record review, observation and interview, it was determined the facility failed to ensure staff provided care and services according to the facility policy for Percutaneous Endoscope Gastrostomy (PEG)

**F 309**

Monitoring Corrective Action

- Compliance rounds will be performed on residents utilizing anti-embolus/compression stockings by Team Leaders and/or Nurse Educator to ensure CNA compliance daily x 2 weeks, then weekly x 4 weeks, then as needed.
- Educational presentation attendance records, audits, and competency documentation will be completed and maintained with progress reports to DON/ADON will provided by the Nurse Educator weekly until completed, then as needed for annual competencies and new hires.
- Random audits will be conducted to monitor application of compression stockings.
- All results will be reported monthly to QI committee

**F 322 SS-D**

NG TREATMENT/ SERVICES - RESTORE EATING SKILLS

Facility will ensure that residents fed by NG or G-tube receive the appropriate treatment and services to prevent related complications and restore, if possible, normal eating skills.

Corrective Action for Resident Cited

- Education provided to Medication Managers re/ Resident #17 and improper management of/med administration by way of enteral tubes.
F 322  Continued From page 7
Tube, and did not follow physician's orders for flushing and administering of medications per PEG tube for 1 of 1 (Resident #17) sampled resident with a PEG tube.

The findings included:

Review of the facility's medication administration via enteral tubes policy documented, "...6. Prepare medications for administration: a. Crush immediate release tablets into a fine powder then dissolve in 30ml [milliliters] of warm water... d. Dilute liquid medications with 10-30ml... of warm water or enteral formula...12. Put 15-30ml in syringe and flush tubing using gravity flow... 13. Pour dissolved/diluted medication in syringe... allowing medication to flow by gravity. 14. Flush tubing with 15-30ml of water, or prescribed amount. If administering more than one medication, flush with 5 ml of water, or prescribed amount between each medication."

Medical record review for Resident #17 documented an admission date of 10/7/10 with diagnoses of Cerebrovascular Disease, Hypertension, Gastroscopy and Arteriosclerotic Dementia. Review of a physician's order dated 1/31/11 documented, "...Aspirin 325MG [milligrams] Tablet enteral tube daily... Cola 100MG per enteral tube b.i.d. [two times a day]... Metoprolol Tartrate 50MG Tablet enteral tube b.i.d... Simvastatin 10MG Tablet enteral tube daily... Valproic Acid 250MG [milligrams] / [per] 5ML [milliliters] 5ML enteral tube... Flush tube with 250mls water q [every] 4 h [hours]... 30ml water flush before and after each med [medication] pass..."

Observations on the 100 hall on 2/23/11 at 8:35
<table>
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<tr>
<th>F 322</th>
<th>Continued From page 8</th>
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<tbody>
<tr>
<td>AM, Nurse #3 placed an empty syringe into Resident #17's PEG tube, poured 30 ml water into the syringe and pushed the water into the tubing to flush the tube. Nurse #3 poured the Colace liquid followed by 30 ml water and pushed the liquids into the tubing. Nurse #3 poured the Valproic Acid liquid into the syringe and followed with a flush of 30 ml of water by push. Nurse #3 poured another 30 ml water into syringe then added dry, crushed medications into the water in the syringe and pushed it into the tubing. Nurse #3 then flushed with 30 ml water by push, and then poured 250 ml water into the syringe and pushed into the tubing. Nurse #3 gave a total of 400 ml of water to flush the PEG during administration of the meds, did not dissolve or dilute the medications, and did not allow the medications or flushes to flow by gravity through the tubing.</td>
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During an interview in the Director of Nursing's (DON) office on 2/24/11 at 9:50 AM, the DON was asked what was the facility policy for flushing and administering meds through a PEG tube. The DON stated, "...Should dilute liquid meds and dissolve any crushed meds... always give by the policy, by gravity, never force or push..."

<table>
<thead>
<tr>
<th>F 323</th>
<th>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</th>
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<tbody>
<tr>
<td>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.</td>
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<tr>
<th>F 322</th>
<th>Monitoring Corrective Action</th>
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<tbody>
<tr>
<td>~Pharmacy Consultant's findings will be reviewed promptly by Nurse Educator and/or DON/DON to maintain compliance, issue follow-up evaluations, and provide 1:1 education and/or disciplinary action as needed.</td>
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<td>~Nurse Educator will maintain record of Medication Administration evaluations and educational presentations conducted upon hire of new Medication Manager, as well as annually/PRN on all Med Managers.</td>
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<td>~Random audits will be conducted to monitor management and medication administration via enteral tube.</td>
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<td>~All results will be reported monthly to QI committee.</td>
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<tr>
<th>F 323</th>
<th>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</th>
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<tr>
<td>The facility will ensure that the resident environment will remain as free of accident hazards as is possible. Each resident will also receive adequate supervision and assistance to prevent accidents.</td>
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<tr>
<td>ID TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES</td>
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<td>F 323</td>
<td>Continued From page 9</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on medical record review, observation and interview, it was determined the facility failed to ensure the environment was free from accident hazards when chemicals were not secured in 1 of 14 (Resident #9) sampled residents' rooms and Random Resident (RR) #1's room.</td>
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<td>The findings included:</td>
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<td>1. Medical record review for Resident #9 documented on admission date of 9/17/10 with diagnoses of Senile Dementia with Delusional Features, Osteoarthritis, Organic Brain Syndrome and Anxiety. Review of the Minimum Data Set (MDS) dated 12/23/10 documented in section C cognitive patterns the resident had severe cognitive impairment.</td>
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<td>Observation in Resident #9's room on 2/22/11 at 2:30 PM, revealed a 10 ounce (oz.) bottle of nail polish remover on the bedside table. The label on the nail polish remover documented &quot;Non-aetone... Extremely flammable. Liquid and Vapors may ignite... Keep out of eyes... Harmful if ingested... Keep out of reach of Children.&quot; The door to Resident #9's room was open with the nail polish remover in view from the hallway.</td>
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<td>2. Medical record review for RR #1 documented on admission date of 11/2/07 with diagnoses of Depressive Type Psychosis and Type 2 Non-Insulin Dependent Diabetes.</td>
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|        | Observation in RR #1's room on 2/22/11 at 2:30 PM, revealed a 10 oz. bottle of nail polish remover on the bedside table. The label on the regular nail polish remover documented
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 323</td>
<td>Continued From page 10</td>
<td>Extremely flammable. Liquid and Vapors may ignite... Keep out of eyes... Harmful if Ingested... Keep out of reach of Children.&quot; The door to RR #1's room was open with the nail polish remover in view from the hallway. RR #1 shared the room with Resident #9.</td>
<td>F 323</td>
<td>Monitoring Corrective Action</td>
<td>- Compliance will be maintained by all staff assigned to patient care areas and monitored by department heads.</td>
<td>03/24/11</td>
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<td>F 333 SS=E</td>
<td>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</td>
<td>The facility must ensure that residents are free of any significant medication errors.</td>
<td>F 333 SS=E</td>
<td>RESIDENTS FREE OF SIGNIFICANT MED ERRORS</td>
<td>The facility will ensure that residents are free of any significant medication errors as it pertains to insulin administration.</td>
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**Corrective Action for Resident Cited**
- Residents # 02, 10, 11, 12 and 17 safety assessed and monitored for signs/symptoms of hyper/hypoglycemia.
- Education provided to Medication Managers regarding insulin administration orders and parameters.
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>F 333</td>
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<td>Continued From page 11</td>
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<td>Identification Other Residents</td>
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<td>R... ONSET (In Hours Unless Noted)... 0.5- [to] 1 [hours]...TYPICAL ADMINISTRATION... 30 minutes prior to meals... Novolin 70/30... ONSET... 30 min [MINUTES]...TYPICAL ADMINISTRATION... 30 minutes prior to meal...&quot;</td>
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<td>All insulin dependent diabetic residents have the potential to be affected by the deficient practice.</td>
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<td>2. Medical record review for Resident #2 documented an admission date of 6/16/10 with diagnoses of Epilepsy, Hypotension, Pressure Ulcer, Diabetes Mellitus, Cerebrovascular Disease and Cirrhosis of the Liver. Review of a physician’s order dated 1/31/11 documented, “...Humalog 100 UNIT/[per] ML [milliliter] Solution sub-Q [subcutaneous] per sliding scale q.i.d. [four times daily], AC [before meals] HS [hour of sleep] 0500 1100 1700 2300 Sliding Scale: 161-180 = [amount of insulin to be administered] Sunits 181-210= Sunits 211-240= Sunits 241-300= Sunits...” The “Task: a Insulin Orders Only” sheet for Resident #2 documented the following incorrect insulin dosages:</td>
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<td>~ Education issued to Medication Managers regarding insulin administration orders and parameters.</td>
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<td>a. 2/8/11 at 1100 result of accucheck 262, dosage given 5 units, correct dosage 9 units.</td>
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<td>~ Pharmacy Consultant contacted to assist in providing education and promoting compliance via 1:1 evaluations of Medication Pass.</td>
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<td>b. 2/15/11 at 0600 results 183, dosage 5 units, correct dosage 6 units.</td>
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<td>c. 2/17/11 at 1100 results 255, dosage 4 units, correct dosage 9 units and 2/17/11 at 2230 results 211, dosage 6 units, correct dosage 8 units.</td>
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<td>d. 2/18/11 at 1100 results 170, dosage 4 units, correct dosage 5 units.</td>
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<td>These were five significant medication errors.</td>
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<td>3. Medical record review for Resident #10 documented an admission date of 8/7/08 with diagnoses of Acute Cerebrovascular Accident, Osteoarthritis, Anemia, Hypertension, Chronic Kidney Disease, Depression, Peripheral Vascular Disease and Diabetes Mellitus Type II. Review of</td>
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Measure Put in Place or System Changes
~ Pharmacy Consultant began competency evaluations with all Medication Managers during medication pass on 2/28/11 and is reporting findings to Nurse Educator, DON, & ADON.
~ Nurse Educator will maintain record of insulin administration evaluations and educational presentations conducted upon hire of new Medication Manager, as well as annually/PRN on all Med Managers.
~ Educational presentation to all licensed staff with post test & attendance log will be provided by Pharmacy on 3/11/2011 regarding insulin administration.
~ Random audits will be conducted to monitor FSBS times and insulin administration.
~ All results will be reported monthly to QI committee.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 333</td>
<td>Continued From page 12</td>
<td>F 333</td>
<td>Monitoring Corrective Action</td>
<td>03-24-11</td>
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<td>a physician's order dated 1/31/11 documented, &quot;NovoLOG 100UNIT/ML Solution sub-Q per sliding scale 1100 1700 2200 0600... 141-160=4units 161-180=5units 181-210=6units...&quot; The &quot;Task: a Insulin Orders Only&quot; sheet for Resident #10 documented the following omission of incorrect insulin dosages: a. 11/15/10 at 2200 result of accucheck 155, dosage given 5 units, correct dosage 4 units. b. 12/15/10 at 2200 result of accucheck 167, dosage blank, correct dosage 5 units. c. 12/18/10 at 2200 result of accucheck 205, dosage blank, correct dosage 5 units. d. 12/21/10 at 2200 result of accucheck 155, dosage 0, correct dosage 4 units. e. 12/30/10 at 2200 result of accucheck 164, dosage 0, correct dosage 5 units. These were five significant medication errors.</td>
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<td>4. Medical record review for Resident #11 documented an admission date of 9/24/08 with diagnoses of Arteriosclerotic Dementia with Delusional Features, Urinary Tract Infection, Depression, Hypertension, Hypertipidemia and Diabetes Mellitus. Review of a physician's order dated 1/31/11 documented, &quot;...NovoLIN R 100 UNIT/ML Solution sub-Q per sliding scale t.i.d. [three times a day] 0600 1130 2100... 161-200 = 2units...&quot; The &quot;Task: a Insulin Orders Only&quot; sheet for Resident #11 documented the following incorrect insulin dosage: a. 11/25/10 at 0800 result of accucheck 168, dosage given 0 units, correct dosage 2 units. This was a significant medication error.</td>
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<td>Review of a physician's order dated 1/31/11 documented, &quot;...NovoLIN 70/30...5 units daily 0630 (As long as resident is eating)...&quot;</td>
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<td>ID PREFIX TAG</td>
<td>ID PREFIX TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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<td>During an interview on the 100 hall on 2/23/11 at 6:10 AM, Nurse #9 was asked when would Resident #11 receive insulin. Nurse #9 stated, &quot;...Got it [insulin] at around 5:30 [AM].&quot; Resident #11 was served the breakfast meal at 7:55 AM. The administration of the insulin more than 30 minutes before the breakfast meal was served resulted in a significant medication error.</td>
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<td>5. Medical record review for Resident #12 documented an admission date of 5/24/01 with diagnoses of Malignant Neoplasm of Prostate, Legal Blindness, Cataract, and Diabetes Mellitus Type I. Review of a physician's order dated 1/31/11 documented, &quot;...NovoLIN R 100 UNIT/ML Solution per sliding scale qid ...151-180 = 6 units... Blood Glucose Checks for sliding scale [insulin] qid [four times a day].&quot;</td>
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<td>Observations on the 100 hall on 2/22/11 at 11:02 AM, Nurse #1 administered 5 units of Novolog insulin to Resident #12. Resident #12 did not receive a meal tray until 12:18 PM. The administration of the insulin more than one hour before lunch was served resulted in a significant medication error.</td>
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<td>6. Medical record review for Resident #17 documented an admission date of 10/7/10 with diagnoses of Cerebrovascular Disease, Hypertension, Hypoglycemia, Hypopotassemia, Arteriosclerotic Dementia and Diabetes Mellitus. Review of a physician's order dated 1/31/11 documented, &quot;NovoLOG 100 UNIT/ML Solution sub-Q per sliding scale q.d. AC / HS 0600 1100 1700 2230 Sliding Scale: 141-160=4units 161-180 =5units...&quot; Review of the &quot;Task: a Insulin Orders Only&quot; sheet for Resident #17 documented the following omission or incorrect insulin</td>
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</table>
**STATEMENT OF DEFICIENCIES**

<table>
<thead>
<tr>
<th>(XI) PROVIDER/ SUPPLIER IDENTIFICATION NUMBER:</th>
<th>445409</th>
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<tr>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>F 333</td>
<td></td>
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<td>Continued From page 14 dosages:</td>
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<td>a. 2/6/11 at 0600 result =178, dosage given 6units, correct dose 5units.</td>
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<td>b. 2/6/11 at 1700 result =143, dosage given 0, correct dose 4units.</td>
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<td>c. 2/14/11 at 1700 result =147, dosage given 0, correct dose 4units.</td>
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<td>These were three significant medication errors.</td>
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| F 371 SS=F |  |  | 483.35(l) 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 |

| F 371 |  |  | F371 SS=F 483.35(i) Food Procure, Store/Prepare/Serve – Sanitary |
|       |  |  | The Facility will procure food from sources approved or considered satisfactory by Federal, State or local authorities: and will store, prepare, distribute and serve food under sanitary conditions. |

Corrective Action for Resident Cited

No specific residents were identified as this deficient practice affects all facility residents.

The following corrective actions have been carried out.

1. All cooking utensils, pots and pans that were hanging over the three compartment sink have been removed from that area and appropriately stored.

2. All Dietary staff have been instructed to wear hair restraints to completely cover their heads, beards and moustaches at all times while in the Dietary department.

3. All cleaning chemical and cleaning supplies such as glass cleaner, stainless steel cleaner, degreasers, de-limers, freezer cleaners, buckets, brooms, dustpans etc., have been stored in a separate storage area.
F 371 Continued From page 15

The findings included:

1. Observations during the initial kitchen tour on 2/22/11 at 10:05 AM, revealed numerous cooking utensils and four large cooking pans hanging above the three compartment sink.

During an interview in the dietary manager's (DM) office on 2/24/11 at 10:05 AM, the DM was asked about storing cooking utensils and pans above the three compartment sink. The DM stated, "I didn't know they [pans and utensils] couldn't be stored there."

2. Review of the facility's dietary services policy documented, "...A. Proper attire...should include a hair covering... Beards must be covered..."

Observations in the kitchen on 2/22/11 at 10:05 AM and 3:40 PM, revealed Dietary Aide #1 working in the kitchen with his moustache uncovered.

Observations in the kitchen on 2/23/11 at 12:30 PM, revealed Nurse #6 in the kitchen without her hair completely covered.

Observations in the kitchen on 2/23/11 at 12:35 PM, revealed Dietary Aide #2 entered the kitchen without his hair or beard covered.

Observations in the kitchen on 2/24/11 at 8:25 AM, revealed Dietary Aide #1 working in the kitchen with his moustache uncovered.

Observations in the kitchen on 2/24/11 at 8:35 AM, revealed Dietary Aide #2 in the dish washing room without his hair or beard covered.

4. All food and beverage items that were observed during the survey as being out of date, not dated at all and stored in the kitchen area, refrigerator or freezer have been discarded.

5. All food serving trays and pans have been washed and air dried before storing them in a clean area.

6.
   A) All food preparation surfaces and supply storage shelf surfaces have been cleaned.
   B) The serving pans have been de-carbonized and the pans and cooking utensils have been cleaned of greasy residue and food particles.
   C) The two stove grills have been cleaned and all pans have been re-washed and stored appropriately.
   D) All Storage carts and storage compartments and utensils have been cleaned. The contaminated straws have been discarded.

7. The three drawer plastic storage container, utensils and the food slicer have all been cleaned and stored appropriately.
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** CRESTVIEW HEALTH AND REHABILITATION  
**Street Address, City, State, Zip Code:** 2030 25TH AVE N, NASHVILLE, TN 37208  
**Identification Number:** 445409  
**Date Survey Completed:** 02/24/2011

<table>
<thead>
<tr>
<th>(X4) ID PRECIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEG IDENTIFYING INFORMATION)</th>
<th>(X2) PROVIDER/SUPPLIER/A IDENTIFICATION NUMBER</th>
<th>(X3) MULTIPLE CONSTRUCTION A. BUILDING</th>
<th>(X3) MULTIPLE CONSTRUCTION B. WING</th>
<th>[X3] DATE SURVEY COMPLETED</th>
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<tr>
<td>F 371</td>
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<td>02/24/2011</td>
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**Identification Other Residents**

All residents have the potential to be effected by this deficient practice.

1. The facility will store cooking and serving utensils away from the three compartment sink to keep them from being contaminated by water that may be splashed on them during the washing of soiled utensils.

2. The facility dietary staff will wear hair restraints to cover all hair on their heads and facial hair such as mustaches and beards.

3. The facility will properly store foods in the refrigerator and freezer and will discard all foods that are out of date.

4. The facility will store brooms, dustpans, and other cleaning supplies in a separate room away from clean utensils and the food preparation area.

5. The Facility will clean all storage surfaces in the food preparation area to ensure that they are free of dust, dirt and food particles.

6. Pans and meals trays will be stored away after they have completely dried and all cooking equipment and food service utensils will be cleaned so as to be free of food particles and greasy residue prior to storing them away in clean storage areas.
**F 371 Continued From page 17**

two quart pitcher of cranberry juice with a clear plastic covering with no date stored in the refrigerator.

Observations in the kitchen on 2/23/11 at 8:23 AM, revealed a container labeled J-LOW (jello) with date labeled 1/17/11, an opened plastic bag of chopped ham with a date of 1/20/11, a tray containing 17 half sandwiches individually wrapped in clear plastic with no label and a half sandwich wrapped in clear plastic labeled "snack 2/17/11" stored in the refrigerator.

Observations in the kitchen on 2/23/11 at 8:45 AM, revealed five packs of rolls dated best by 2/19/11 and four packs of rolls dated best by 2/21/11.

Observations in the kitchen on 2/23/11 at 8:45 AM, revealed an opened two quart container of ice cream with no date label stored in the freezer.

During an interview in the kitchen on 2/22/11 at 10:15 AM, the DM was asked about the opened water bottle. The DM stated, "I do this all the time, somebody's drink." When asked about the open, undated container of pimento cheese, the DM stated, "It [container of pimento cheese] should have been dated when opened."

During an interview in the kitchen on 2/22/11 at 3:35 PM, the DM was asked about the bologna and juices. The DM stated, "This is late [date]. These [bologna and juices] should have been thrown out."

During an interview in the kitchen on 2/23/11 at 8:23 AM, the DM was asked about the Jello, sandwiches and ham. The DM stated, "The Jello..."

**F 371 Measure Put in Place or System Changes**

All dietary staff will be educated by the Registered Dietician in relation to sanitation and proper cleaning, proper food storage, proper cleaning and storage of cooking utensils, pots, pans and dietary equipment. Education will be completed by 03/24/2011. Work flow sheets will be created by the dietary manager to ensure that the process of cleaning in the dietary department is completed each day. Dietary manager will review completed sheets and monitor sanitation in the dietary department. Sanitation will also be monitored monthly by consulting Registered Dietician.

**Monitoring Corrective Action**

The Dietary Manager will submit monthly RD Reports along with her own sanitation audits and corrective actions to the Quality Improvement committee on a monthly basis for review. The administrator will be responsible for reviewing these reports. Findings will be analyzed and QI Committee will evaluate the effectiveness of present plan and recommend revisions as needed.
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<th>Description</th>
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<td>Continued From page 18</td>
<td>F 371</td>
<td>is out of date and should be thrown away. The sandwiches should have been dated. The ham should be thrown away. I didn't know it [ham] was open.</td>
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<td>During an interview in the kitchen on 2/23/11 at 8:45 AM, the DM was asked about the ice cream. The DM stated, &quot;Activities put it [ice cream] in there [freezer] and they should have dated it. The DM was asked about the rolls. The DM confirmed the rolls were out of date.</td>
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<td>5. Review of the facility's dietary services policy documented, &quot;...T. All pots and pans must be air dried after the final sanitizing rinse...&quot;</td>
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<td>Observations in the kitchen on 2/22/11 at 10:15 AM, Dietary Aide #3 removed wet meal trays from the ware washer and stacked them on top of each other in the storage cart.</td>
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<td>Observations in the kitchen on 2/23/11 at 9:05 AM, revealed two serving pans stacked on top of each other stored wet nested with other cooking pans under the food preparation table.</td>
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<td>During an interview in the kitchen on 2/23/11 at 9:05 AM, the DM stated, &quot;The pan should have been allowed to air dry before being put on the shelf.&quot;</td>
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<td>6. Review of the facility's dietary services policy documented, &quot;...U. Steam tables... 3. Must be kept in clean and sanitary condition through regular cleaning... D. All work surfaces, utensils and equipment should be cleaned and sanitized after each use... R. All food grinders, choppers, mixers, etc. [etcetera] should cleaned sanitized, dried, and reassembled after each use.&quot;</td>
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Observations in the kitchen on 2/23/11 at 9:05 AM, revealed the following:
a. Shelves under two food preparation areas and the shelf under the steam table had dust, dirt, and dried food particles on the surfaces.
b. Shelf under food preparation area had clean cooking utensils with a large serving pan on top of the clean pans. The pan had carbon buildup and the exterior of the pan was greasy and sticky to touch.
c. Two stove grills with dried food particles and one steam table cover with dried food particles were stored under the steam table on a shelf with clean cooking pans.
d. Storage cart had dust, dirt, and dried food particles on the bottom shelf and clean trays were stored on this shelf. The compartments on top of the cart had dust and dried food particles in the compartments. Clean utensils and straws were stored in the compartments.

Observations in the kitchen on 2/23/11 at 12:20 PM, revealed a three drawer plastic storage container on the shelf under the food preparation area with dirt on the outside, dried food particles and a dried orange substance inside the top drawer. Clean utensils were stored in the drawer. The meat slicer had a dried meat particle on the base and was covered with a plastic wrap.

During an interview in the kitchen on 2/23/11 at 9:05 AM, the DM was asked about the shelves and cooking equipment. The DM stated, "It needs to be cleaned." When asked about a cleaning schedule for equipment and the kitchen. The DM stated, "They [dietary staff] know what they need to do, they're just not doing it [cleaning]."
F 371
Continued from page 20
During an interview in the kitchen on 2/23/11 at 12:20 PM, the DM confirmed the plastic container and meat slicer needed to be cleaned.

F 441
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

F 441 - SS=E
Corrective Action for Resident Cited
~Policy/Procedure review related to hand hygiene practices of nurse #12 related to wound care and nurse #4 during med pass.
~Education provided regarding infection control-related observations such as Medication Managers carrying medication/prefilled syringes in pockets & application of transdermal medication systems without gloves, as well as CNAs failure to demonstrate proper hand hygiene during meal times and other resident care times and storage of contaminated trays with un-served meal trays.

Identification Other Residents
~All residents have the potential to be affected by the deficient practice.
~All references to hand washing and hygiene policy will be clarified and updated and reflect current CDC guidelines and recommendations.
~Education provided regarding hand hygiene to employees.
Continued From page 21
Infection.

This REQUIREMENT is not met as evidenced by:

Based on policy review, observations and interviews, it was determined 5 of 10 (Nurses #2, 3, 4, 8 and 9) nurses failed to wash their hands, practice proper hand hygiene and/or transported medications properly to prevent the potential spread of infection. Two (2) of 3 Certified Nursing Assistants (CNA #2 and 3) failed to wash hands after direct resident contact or placed a contaminated tray back on a meal cart with trays that had not been served.

The findings included:

1. Review of the facility's "Wound Care Protocols" documented, "...Wash hands... Prepare a clean field... Open sterile dressings and supplies using clean technique... Wash hands... Put them on the clean field... Put on clean gloves and remove soiled dressing and discard immediately in plastic bag. Remove gloves, place in plastic bag. Wash hands. Put on a pair of clean gloves... Wash hands. Put on a pair of clean gloves..."

Observations in Resident #2's room on 2/23/11 at 8:56 AM, Nurse #9 performed wound care on Resident #2's coccyx. Nurse #9 was not observed to wash her hands with soap and water before starting the wound care, during the wound care or after completing wound care on Resident #2.

Observations in Resident #12's room on 2/23/11 at 9:12 AM, Nurse #9 performed wound care on...
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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>COMPLETION DATE</th>
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<td>F441</td>
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<td>Resident #12's right hip. Nurse #9 was not observed to wash her hands with soap and water before, during or after performing wound care on Resident #12.</td>
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<td>During an interview in the conference room on 2/24/11 at 7:25 AM, Nurse #9 confirmed that she did not wash her hands with soap and water during the dressing changes.</td>
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<td>2. Review of the facility's &quot;Your 5 Moments for Hand Hygiene&quot; policy documented, &quot;Clean your hands; 1. BEFORE TOUCHING A PATIENT 2. BEFORE CLEAN / ASEPTIC PROCEDURE 3. AFTER BODY FLUID EXPOSURE RISK ...5. AFTER TOUCHING PATIENT SURROUNDINGS...&quot;</td>
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<td>a. Observations in the first floor dining room on 2/23/11 at 7:25 AM, CNA #2 removed the leg rest from a resident's wheelchair (w/o), moved the resident's feet and then applied a clothing protector on the resident. CNA #2 proceeded to place a clothing protector on another resident and then filled the ice chest with ice, took the ice chest to the clean utility room, then returned to the dining room and poured cups of coffee for residents. CNA #2 was not observed to wash his hands or use hand gel after direct resident contact.</td>
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<td>b. Observations during tray pass on the 100 hall in room 111 on 2/23/11 at 7:30 AM, Nurse #8 pulled the resident up in the bed, cranked the bed up, pulled the overbed table to the resident, set the tray on the table, opened the plate cover, opened the cereal, silverware and orange juice without washing his hands or using sanitizer before setting up the meal tray.</td>
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During an interview in the Director of Nursing's (DON) office on 2/24/11 at 3:30 PM, the DON was asked about pulling the resident up and cranking up the bed then settling the tray up. The DON stated, "They [staff] should have used sanitizer or washed their hands before they took the lid off or started doing anything with the tray."

3. Observations during tray pass on the 100 hall in room 103 on 2/23/11 at 12:54 PM, CNA #3 delivered the food tray, went to the kitchen, came back to room, noticed the resident had the wrong food tray, removed the tray which the resident had been eating from and put it back on the food cart with the clean trays.

During an interview in the DON's office on 2/24/11 at 3:30 PM, the DON was asked about the meal tray being put back on the clean cart. The DON stated, "That's an infection control issue. Should have taken the tray back to the kitchen to the dirty dishes and gotten her another tray. She [CNA #3] should have checked the tray card."

4. Review of the facility's hand hygiene policy documented, "...When decontaminating hands with an alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dried..."
F 441  Continued From page 24
   went into the hallway and applied sanitizing hand
gel to her right palm, quickly rubbed her palms
together, and returned to the med cart. Nurse #4
did not cover all surfaces of her hands and
fingers with the sanitizing gel and rub palms
together until hands dried.

5. Observations on the 200 hall on 2/23/11 at
6:30 AM, Nurse #2 removed a transdermal patch
from the wrapper, initialed and dated the patch
and placed the patch inside her pocket. Nurse #2
stated, "I'll wait till they [staff member] bring her
back to her room [to apply the patch]."

Observations on the 200 hall on 2/23/11 at 8:45
AM, Nurse #3 removed a pre-filled syringe from
the medication cart and placed the syringe in his
pocket.

Observations on the 200 hall on 2/23/11 at 9:20
AM, Nurse #3 removed an inhaler from the
medication cart and placed the inhaler in his
pocket.

During an interview in the DON's office on 2/24/11
at 9:50 AM, the DON was asked how should the
nurses transport medication from the medication
cart to the resident's room. The DON stated,
"Carry all the meds [medications] in a container,
not in a pocket. They know better than that."