**Statement of Deficiencies and Plan of Correction**

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>N 521</th>
<th>1200-6-6-.05(8) Admissions, Discharges, and Transfers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N 521</td>
<td>The facility discharges patients with written orders from the attending physician or through other legal processes and timely notification of next of kin and/or sponsor or authorized representative, if any.</td>
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<td>Nurse's note stated that the physician, family and hospice were notified regarding the patient's discharge. The nurse failed to enter the order for discharge in the computer.</td>
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<td>In-service education for licensed nurses was overseen by the Director of Nursing on the process for entering orders for discharged patients. This was completed on 12/16/11.</td>
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<td>The Health Information Director will conduct a chart review of all discharges for the next 3 months to monitor for compliance of discharge orders being present. These will be presented to the Director of Nursing and the Quality Assurance Committee. The monitor and education will continue as determined by the Director of Nursing or as directed by the Quality Assurance Committee which consists of the administrator, DON, medical director, associate medical director, registered dietitian, social worker, health information manager, housekeeping supervisor, maintenance supervisor, activity director, Administrative Nurses, and facility director of rehab.</td>
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<tr>
<th>ID Prefix Tag</th>
<th>N 829</th>
<th>1200-6-6-.06(3) Basa Services</th>
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<tbody>
<tr>
<td></td>
<td>N 829</td>
<td>(3) Infection Control.</td>
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<td>8. Water pitchers, glasses, thermometers, emesis basins, douche apparatus, enema apparatus, urinals, mouthwash cups, bedpans and similar items of equipment coming into intimate contact with residents shall be disinfected or sterilized after each use unless</td>
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</tbody>
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**Signature**

[Signature]

**Title**

[Title]

**Date**

[Date]
N 629: The facility has established and maintains 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.

The Director of Nursing immediately "reeducated" the nurse regarding the proper procedure for cleaning the glucometer machine. Physicians, patients and responsible parties were notified of the incident and appropriate interventions were taken.

12/5/11 (9:30pm) All licensed nurses on duty were in-service immediately on the policy and procedure for cleaning the glucometer. (10:45pm) 11pm-7pm nurses were in-service on the policy and procedure with return demonstrations verified. In-services were conducted by the Director of Nursing.

Each nurse in-service verbalized to the Director of Nursing the correct procedure.

In-services for all licensed nurses were overseen by the Director of Nursing with return demonstrations verbalized by each nurse.
N 629, Continued from page 2

1. Review of the "Centers for Disease Control and Prevention" guidelines documented, 
   "...infection prevention during Blood Glucose Monitoring and Insulin Therapy... Whenever possible, blood glucose meters should be assigned to an individual person and not be shared. If blood glucose meters must be shared, the device should be cleaned and disinfected after every use..."

2. Review of the facility's "Glucometer Cleaning Guideline" policy documented, 
   "...Glucometers will be disinfected between patient use by the nurse..."


Observations during medication administration on 12/5/11 at 9:10 PM, Nurse #1 entered Resident #6's room and performed an accucheck on Resident #6. Nurse #1 left Resident #6's room and returned to the medication cart. Nurse #1 obtained supplies and performed an accucheck on Resident #12 without cleaning the contaminated accucheck machine.

Observations during medication administration in Resident #12's room on 12/6/11 at 5:20 PM, Nurse #1 entered the room and obtained an accucheck on Resident #12. Nurse #1 did not clean the accucheck machine at any time during this observation.

There was one accucheck machine used for Resident #6 and Resident #12, who required a finger stick blood glucose test. Resident #6 and Resident #12 were observed to have a finger

A quality assurance study began on 12/6/11, conducted by the Director of Nursing in which 10 (ten) different random licensed nurses per week for six weeks will be observed demonstrating the facility's procedure for cleaning glucometers at each use.

The Director of Nursing will monitor compliance of this study and report to the facility's Quality Assurance Committee. The study will continue as determined by the Director of Nursing or as directed by the Quality Assurance Committee which consists of the administrator, DON, medical director, associate medical director, registered dietician, social worker, health information manager, housekeeping supervisor, maintenance supervisor, activity director, Administrative Nurses, and facility director of rehab.

12-6-11
N 629 Continued From page 3

4. During an interview in the hallway outside Room 216 on 12/5/11 at 5:25 PM, Nurse #1 was asked how she cared for the glucometer when using it for glucometers for the residents. Nurse #1 stated, "...use this glucometer for all residents on my cart... glucometer is cleaned every night on 3rd shift with germicidal wipe cloth...clean in between if it gets dirty..."

During an interview in the private dining room on 12/5/11 at 7:00 PM, the Director of Nursing (DON) was asked how she expected the nurses to care for the glucometer. The DON stated, "...clean after each use... between every patient... let it dry for two minutes..."

I am an interviewer in the hallway outside room 201 on 12/5/11 at 8:48 PM, Nurse #1 stated, "...I don't know what I was thinking earlier... we wipe the glucometer down between each patient... wipe it off before I use it [glucometer machine]... I'll wipe it down before I leave..."

N 645 1200-8-6.06(3)(k) Basic Services

(3) Infection Control.
N 549 Continued From page 4

(k) Space and facilities for housekeeping equipment and supply storage shall be provided in each service area. Storage for bulk supplies and equipment shall be located away from patient care areas. The building shall be kept in good repair, clean, sanitary and safe at all times.

This Rule is not met as evidenced by:
Type C Pending Penalty #19

Tennessee Code Annotated 88-11-804(c)(19):
The nursing home shall be clean and sanitary and in good repair at all times.

Based on policy review, observation and interview, it was determined the facility failed to ensure the environment was clean and sanitary as evidenced by a soiled shower chair in 1 of 2 (2nd floor shower room) shower rooms.

The findings included:

1. Review of the facility's "Blood-Borne Pathogen Exposure Control Plan" policy documented, "...GENERAL. Any equipment used mutually on patients (blood pressure cuff, stethoscope, etc. [bilateral]) must be cleaned and decontaminated with an FDA-approved germicide after contact with body fluids."

Review of the facility's "SHOWERCHAIR CLEANING SCHEDULE" documented, "Patient shower chairs need periodic cleaning. Shower chairs are to be wiped down with Clorox germicidal wipes between use or left for housekeeping to clean if grossly soiled. Shower chair cleaning is the responsibility of the CNA's..."
N 645; Continued From page 5

"(Certified Nursing Assistant). Clorox germicidal wipes are located in the 2nd & [and] 3rd floor janitor closets."

2. Observations in the 2nd floor shower room on 12/5/11 at 11:00 AM, revealed a brown substance smear on the seat of the shower chair located in the shower stall.

Observations in the 2nd floor shower room on 12/8/11 at 11:08 AM and 12/7/11 at 8:45 AM, revealed a brown substance on the seat of the shower chair located in the shower stall.

3. During an interview with Resident #5 on 12/5/11 at 1:55 PM, Resident #5 stated that his semi-private room did not have a shower, therefore, he went to the shower room three times a week.

During an interview with the Housekeeping Supervisor's office on 12/7/11 at 8:30 AM, the Housekeeping Supervisor was asked about the cleaning schedules for the shower rooms. The Housekeeping Supervisor stated, "...shower rooms are cleaned daily by housekeeping, between showers it's either the nurse, CNA or housekeeping. All carts [housekeeping carts] and floors have bleach [antiseptic cleaner] and Clorox Germicidal wipes available..."

During an interview in the 2nd floor shower room on 12/7/11 at 12:40 PM, Housekeeper #1 confirmed there was a brown substance on the shower chair seat. Housekeeper #1 cleaned the seat and stated, "...it [brown substance] did come..."

Overseen by the Director of Nursing, random checks of at least 10 shower chairs for cleanliness will take place weekly for 6 weeks. Director of Nursing will monitor results of this study and present the results to the Quality Assurance Committee. The monitor and in-service training will continue as determined by the Director of Nursing or as directed by the Quality Assurance Committee which consists of the administrator, DON, medical director, associate medical director, registered dietitian, social worker, health information manager, housekeeping supervisor, maintenance supervisor, activity director, Administrative Nurses, and facility director of rehab. 12-16-11
N 845; Continued From page 6

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<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEG IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>N 845</td>
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During an interview in the business office hallway on 12/7/11 at 1:30 PM, the Administrator was asked about his expectations for cleaning the shower equipment after use. The Administrator stated, "...Housekeeping supplies are on the floors so that chairs [shower chairs] are cleaned between use."

During an interview on the 2nd floor hall outside the shower room on 12/7/11 at 3:40 PM, the Assistant Director of Nursing (ADON) was asked about shower equipment cleaning. The ADON stated, "...CNAs are responsible for cleaning shower chairs after each use... the shower chair should be sanitized between residents."