SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

F 159
483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS

Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.

The facility must deposit any resident's personal funds in excess of $50 in an interest-bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the

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A. Beginning the weekend of January 11, 2014, spending money will be available on weekends (Saturday and Sunday) for residents between the hours of 10 a.m. and 12 noon. Residents will contact Nursing Supervisor to request spending money by calling the Information Desk and being transferred to the Nursing Supervisor.

B. Nursing Supervisor looks up the resident's account on report provided to ensure there is money available to withdraw and to be sure there are no "special comments/notes" on the account limiting the funds to be dispersed.

C. Provided there are adequate funds, Nursing Supervisor completes the Signatures for Weekend Spending Money Form by writing resident's name, amount of cash to be given, date and the resident signs. In the event the resident is unable to sign, the nursing supervisor must sign resident's name/by their name, have it witnessed and the resident is given the withdrawal amount. (See Attachment A)
F 159 Continued From page 1

SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:

Based on interview, it was determined the facility failed to ensure residents had access to petty cash when requested on an ongoing basis for 2 of 3 (Residents #60 and Resident #141) sampled residents interviewed with a personal funds account of the 47 residents included in the stage 2 review.

The findings included:

1. During an interview in Resident's #60's room on 12/16/13 at 4:21 PM, Resident #60 was asked, "Can you get your money when you need it, including on weekend?" Resident #60 stated, "No, closed on weekend..."

2. During an interview in Resident #141’s room on 12/16/13 at 3:46 PM, Resident #141 was asked, “Can you get your money when you need it, including on weekend?” Resident #141 stated, “No one here on weekend to give out money...”

3. During an interview in the mini conference room on 12/18/13 at 2:05 PM, the Patient Account Specialist was asked what the hours of operation were and the days of the week the office was open for residents to request money from their account. The Patient Account Specialist stated, "7:30 AM til [until] 4:00 PM, Monday..."
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(x1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER: 445033

(x2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(x3) DATE SURVEY COMPLETED: 12/18/2013

NAME OF PROVIDER OR SUPPLIER:
BORDEAUX LONG TERM CARE

STREET ADDRESS, CITY, STATE, ZIP CODE:
1414 COUNTY HOSPITAL RD
NASHVILLE, TN 37218

(x4) ID PREFIX TAG
SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 159 Continued From page 1

SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:

Based on interview, it was determined the facility failed to ensure residents had access to petty cash when requested on an ongoing basis for 2 of 3 (Residents #60 and Resident #141) sampled residents interviewed with a personal funds account of the 47 residents included in the stage 2 review.

The findings included:

1. During an interview in Resident's #60's room on 12/16/13 at 4:21 PM, Resident #60 was asked, "Can you get your money when you need it, including on weekends?" Resident #60 stated, "No, closed or weekend..."

2. During an interview in Resident #141's room on 12/16/13 at 3:46 PM, Resident #141 was asked, "Can you get your money when you need it, including on weekend?" Resident #141 stated, "No one here on weekend to give out money..."

3. During an interview in the mini conference room on 12/16/13 at 2:05 PM, the Patient Account Specialist was asked what the hours of operation were and the days of week the office was open for residents to request money from their account. The Patient Account Specialist stated, "7:30 AM til [until] 4:00 PM, Monday..."

Residents and Responsible Parties will be notified of spending money being available on weekends by a Sign posted outside of Accounts and Records Management Cashier Window, a Letter being included in the Quarterly Statements and in Family and Resident Council meetings during the month of January and February.

D. The Accounts and Records Manager or designee will audit 20% of residents with trust fund accounts to determine the availability of their funds on weekends for three months. When 95% of compliance has been reached for 3 consecutive months, audits will be conducted at the discretion of the Accounts and Records Manager or Director of Quality/Risk Management. Audit results will be reported monthly in Quality Council Committee by the Accounts and Records Manager or designee.
F 159 Continued From page 2
through Friday... Most of the residents know our hours so they come and get their money for the weekend on Friday."

F 241 : 483.15(a) DIGNITY AND RESPECT OF PERSONALITY
SSD 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 observation and interview, it was determined the facility failed to enhance the residents dignity by serving milk in milk cartons during 2 of 2 (lunch 12/16/13 and dinner 12/17/13) dining observations and by standing while feeding Resident #9.

The findings included:

1. Observations during dining on Birmingham (B) 3 on 12/16/13 11:56 AM, revealed 8 of 26 residents observed being served meal trays, were served milk in milk cartons.

Observations during dining on Birmingham 2 on 12/17/13 at 5:55 PM, revealed 3 of 4 residents observed being served meal trays, were served milk in milk cartons.

During an interview on Birmingham 2 in the Patient Care Manager's office on 12/18/13 at 2:41 PM, Nurse #2 was asked how should milk be served. Nurse #2 stated, "...Milk should be served in a glass..."
## F-241
Continued From page 3

During an interview on Birmingham 3 in the Patient Care Manager's office on 12/18/13 at 2:51 PM, Nurse #3 was asked how milk should be served. Nurse #3 stated, "Expect them [staff] to serve milk in a glass..."

2. Observations during dining on Birmingham 3 west hall on 12/16/13 at 12:31 PM, revealed certified nursing assistant (CNA) #1 stood over Resident #9 while feeding him.

During an interview on Birmingham 2 in the Patient Care Manager's office on 12/18/13 at 2:41 PM, Nurse #2 was asked how staff should assist residents to eat. Nurse #2 stated, "...[staff] Should be at eye level. Most of them would be sitting..."

During an interview on Birmingham 3 in the Patient Care Manager's office on 12/18/13 at 2:51 PM, Nurse #3 was asked how staff should assist residents to eat. Nurse #3 stated, "...[staff] would be sitting facing the resident [when assisting to eat]."

## F-280
483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

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...
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>F 280</td>
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<td>Continued From page 4 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.</td>
<td>F 280</td>
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<td>Resident #268 had an order for a Foley catheter that had not been care planned. Physician was contacted regarding Foley catheter. Physician orders were received on December 16, 2013 to discontinue the Foley catheter. The resident's care plan has been updated to reflect resident's current bladder status. (See Attachment G)</td>
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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 update and revise the care plans related to falls and/or urinary catheters for 3 of 47 (Residents #180, 242 and 268) sampled residents included in the stage 2 review.

The findings included:

1. Review of the facility's care plan policy documented, "...Care Plans are to be updated as needed... to include new...interventions..."

2. Medical record review for Resident #180 documented an admission date of 12/22/11 with diagnoses of Alzheimer's Disease, Dementia, Chronic Paranoid Psychosis, Benign Prostatic Hypertrophy, Hypertension, Ischemic Heart Disease, Atrial Flutter, Debilily, Esophageal reflux disease, Anxiety and Depression. Review of the fall event assessment dated 11/25/13 at 11:15 AM documented, "...housekeeping staff found lying on floor beside bed... New Intervention... Encourage resident to call for assistance..." The care plan dated 11/4/13 was not updated to include the new intervention implemented for the
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During an interview in the Director of Nursing's (DON) office on 12/18/13 at 10:35 AM, the DON was asked would it be expected to add new fall interventions to the care plan. The DON stated, "...I would expect it to be put on the care plan..."

2. Medical record review for Resident #242 documented an admission date of 8/23/13 with diagnoses of Postoperative Respiratory Failure, Restrictive Lung Disease, Obesity, Obstructive Sleep Apnea, Right Hemidiaphragm Dysfunction, Hypertension, Atrial Fibrillation, Congestive Heart Failure, Tracheostomy, Malnutrition and Debility. Review of the care plan for Resident #242 dated 9/11/13 documented, ",...INCONTINENCE...
Resident occasionally incontinent with bladder/bowel,..." Review of the quarterly Minimum Data Set (MDS) dated 11/27/13 documented Resident #242 was always incontinent of bladder and bowel, the care plan was not updated to reflect that Resident #242 is always incontinent.

During an interview at Birmingham 2 nurses’ station on 12/18/13 at 9:45 AM, Nurse #2 was asked should there be a care plan for always incontinent. Nurse #2 stated, "Yes."

3. Medical record review for Resident #268 with an admission date 12/9/13 with diagnoses Anoxic brain damage, Pulmonary insufficiency following cardiac arrest, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Ischemic heart disease, Hypertension, Anemia, Diabetes Mellitus, Diabetic neuropathy, Deblity, Dysphagia, Severe protein malnutrition, Gastroparesis, Gastrostomy, Barrett's

Learning Objectives:

- Understanding the review of care Plan to ensure it has been appropriately updated with Foley catheter orders/Continence status
- Licensed nursing staff will understand that new Foley catheters must be added to care Plans

D. The Restorative Care Nurse, Resident Assessment Manager, PCM, Nursing Supervisor, DON or Director of Quality/Risk Management will audit:
   a) All residents who have Foley catheters to ensure there is a correct care plan has been performed. (See Attachment M)
   b) All residents continence states to have been care planned. (See Attachment N)
   c) All residents who have had a fall to ensure they are updated with new interventions. (See Attachment O)

The threshold for audits compliance for the Quality Improvement process will be set at 95%. Once the threshold has been met for three (3) consecutive months, audits will be conducted as the discretion of the DON or Director of Quality/Risk Management. Audit results will be reported in monthly Quality Council Committee.
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| F 280 |   |   | Continued From page 6. Esophagus, Hiatal hernia, Anxiety, Thrombocytosis, Tracheostomy, history of coccyx fracture, Urinary devices, Vascular catheter and acute respiratory infections. The entry MDS dated 12/9/13 had no documentation for bladder incontinence. The admission physician's orders dated 12/9/13 had no documentation for use of a Foley catheter. The "New Admission Orders / Interim Plan of Care" dated 12/9/13 had no documentation under the catheter care section. Review of the interdisciplinary progress notes documented the following: a. 12/9/13 - "...foley patent draining yellow urine..." b. 12/11/13 - "...foley draining scant amount of yellow urine to bedside bag..." Review of the care plan dated 12/10/13 had no documentation for urinary continence or the use of the Foley catheter. Review of the physician's orders dated 12/16/13 documented, "1. D/C [discontinue] Foley..." Observations in Resident #268's room on 12/16/13 at 5:42 PM, revealed Resident #268 lying in bed with the Foley catheter in privacy bag. Observations in Resident #268's room on 12/17/13 at 8:09 AM, revealed Resident #268 did not have a Foley catheter. During an interview at the Birmingham 2 nurses' station on 12/18/13 at 2:20 PM, Nurse #2 was asked about the documentation for a Foley on the new admission orders / interim care plan. Nurse #2 stated, "...that is an oversight, in this box should have checked keep Foley in or D/C Foley..."
F 280 Continued From page 7 on admission..."
F 315: 483.25(d) NO CATHETER, PREVENT UTI, SS=D
RESTORE BLADDER

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 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 medical record review, observation and interview, it was determined the facility failed to obtain an appropriate diagnoses for the use of a Foley catheter and/or did not provide bowel and bladder training for 2 of 47 (Residents #54 and 242) sampled residents included in the stage 2 review.

The findings included:
1. Medical record review for Resident #54 with an admission date 11/19/13 with diagnoses Anemia, Coronary Artery Disease, Hypertension, Gastroesophageal Reflux Disease, Pneumonia, Diabetes Mellitus, Hyperlipidemia, Arthritis, Seizure Disorder, Depression, Respiratory Failure, Chronic Obstructive Pulmonary Disease, Osteoarthritis and Feeding difficulties. Review of the physician's orders dated 11/19/13 documented, "...Indwelling Foley Catheter Size #
Residents will have a continence assessment B645.0904 (See Attachment S) completed upon admission to determine their continence level and ability to participate in toileting program. These will be updated quarterly and with any change of continence status.

Beginning December 23, 2013 an audit was performed to look at all resident’s Bowel and bladder assessments/MDS/ Care plans (See Attachment N) to ensure continuity of care regarding resident bowel and bladder status.

C. Beginning on December 19, 2013 a Weekly audit of all New Admissions paperwork including Admission orders will be conducted by the PCMs to ensure that all patients admitted with a Foley catheter have either an order to discontinue the device or a valid diagnosis and signed Physician’s Order for a Foley catheter any inaccuracies were corrected.

Beginning December 23, 2013 all nursing staff will be educated on the completion of the Admission Audit Tool (See Attachment T). With education completed on January 17, 2014. The nurse on the shift at the time of admission and the nurse that follows will both sign the audit tool. All items on the audit, including Presence of Foley, Justification order, and size will be completed. This will be turned in to the Charge Nurse who will sign off on it and then give it to the PCM.
F 315 Continued From page 8

(16 f [French] /10ml [milliliter]) change (Q [every] 30 Days & [and] PRN [as needed]) (DX [diagnosis]: SACRAL EXCORIATION...)

Review of the admission minimum data set (MDS) dated 11/23/13 documented, Resident #54 had an indwelling catheter and urinary continence was not rated.

Review of the care plan dated 11/25/13 documented, "...INCONTINENCE / INDWELLING CATHETER: She has a 16F/10ml indwelling catheter intact / patent to BSD [bedside drainage] c/t [due to] sacral excoriation..."

Observations in Resident #54’s room on 12/18/13 at 11:10 AM, revealed Resident #54 with a Foley catheter in privacy bag.

During an interview at the Birmingham 2 nurses’ station on 12/18/13 at 2:10 PM, Nurse #2 was asked if sacral excoriation is a proper diagnoses for a Foley. Nurse #2 stated, "No."

2. Medical record review for Resident #242 documented an admission date of 8/23/13 with diagnoses of Postoperative Respiratory Failure, Restrictive Lung Disease, Obesity, Atrial Fibrillation, Right Ventricular Failure, Obstructive Sleep Apnea, Hypertension, Congestive Heart Failure, Tracheostomy, Malnutrition and Dehiscence. Review of the interdisciplinary progress notes dated 8/28/13 at 4:30 PM documented, "...cont. [continued] of B&B [bowel and bladder]. Urinal provided 350 cc [cubic centimeters] clear yellow urine noted..." Review of section H of Resident #242’s MDS dated 9/4/13 documented Resident #242 was occasionally incontinent. Review of the care plan dated...
F 315. Continued From page 9
9/11/13 documented, "...INCONTINENCE...
Resident occasionally incontinent with bladder/bowel..." with no intervention for any type
of toileting program to maintain or restore
continence. Review of section H of the quarterly
MDS dated 11/27/13 documented Resident #242
was always incontinent of bladder and bowel.

During an interview at the Birmingham 2 nurses
station on 12/18/13 at 9:45 AM, Nurse #2 was
asked should a bowel and bladder program have
been started for Resident #242. Nurse #2 stated,
"Yes."

F 332. 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 review of the "Geriatric Medication
Handbook", policy review, medical record review,
observation and interview, it was determined the
facility failed to ensure 3 of 7 (Nurses #6, 7 and 8)
medication nurses administered medications with
a medication error rate of less than five percent
(%). There were 3 medication errors made out of
25 opportunities for error, which resulted in a
medication error rate of 12%.

The findings included:

1. Review of the facility's medication
administration policy documented, "...Novolog:
Snack or meal within 5-10 minutes of

D. The Resident Assessment
Manager, Restorative Care Nurse,
PCM. Nursing Supervisor, or
Director of Quality/Risk
Management will audit

a) All residents who have a
Foley catheter to ensure
there is a proper diagnosis
(See Attachment M)
b) All residents' bowel and
bladder status to ensure
care plan has been
provided. (See
Attachment N)

The threshold for compliance for the Quality Improvement process
will be set at 95%. Once the threshold has been met for three
(3) consecutive months, audits will
be conducted as the discretion of
the DON or Director of Quality/Risk
Management. Audit results will
be reported in monthly Quality Council
Committee.

F 332

A. Observation of during Med pass,
nurse administered 2 units of
Novolog Insulin for sliding scale
orders for blood sugar greater 180.
Meal was not served for 1 hour and
26 minutes. 2 separate residents
both received 2 puffs of Inhalers. Of
the 2 nurses giving the inhalers,
neither did not wait the required 1
minute between the puffs.
Continued From page 10
administering the insulin...

Medical record review for Resident #306 documented an admission date of 6/28/13 with diagnoses of Vascular Dementia, Intracerebral Hemorrhage, Hypertension, Hyperlipidemia, Atrial Fibrillation, Anxiety and Diabetes Mellitus. Review of a physician’s order dated 7/19/13 documented, "...ACCU CHECKS BID [twice daily] WITH NOVOLOG INSULIN SSI [sliding scale insulin] ...IF BS [BLOOD SUGAR] is > [greater than] 180 SLIDING SCALE INSULIN AS INDICATED...

Observations in Resident #306’s room on 12/18/13 at 4:09 PM, revealed Nurse #6 administered 2 units of Novolog insulin to Resident #306. Resident #306’s meal tray had not been delivered as of 5:35 PM, 1 hour and 26 minutes after administration of the insulin. Resulted in medication error #1.

During an interview on the south hall, second floor Birmingham on 12/18/13 at 5:10 PM, Nurse #6 was asked about the administration of Novolog insulin in relation to meal time. Nurse #6 stated, "...[Novolog insulin] should be given 30 minutes before meals..."

During an interview on the north hall, fourth floor Birmingham on 12/18/13 at 5:30 PM, Nurse #9 was asked about the administration of Novolog insulin in relation to meal time. Nurse #9 stated, "...Normally Novolog is given with meals..."

Review of the "Geriatric Medication Handbook", tenth edition, page 57, documented, "...If another puff of the same or different medication is required, wait 1-2 minutes... then repeat procedure..."
**F 332 Continued From page 11**

a. Medical record review for Resident #16 documented an admission date of 8/27/13 with diagnoses of Hepatic Coma, Coronary Artery Disease, Hypertension, Osteoarthritis, Chronic Obstructive Pulmonary Disease and Psychosis. Review of a physician's order dated 9/16/13 documented, "...COMBIVENT INHALER 2 PUFFS..."

Observations in Resident #16's room on 12/18/13 at 7:41 AM, Nurse #7 administered 2 puffs of a Combivent Inhaler to Resident #16. Nurse #7 waited 25 seconds between puffs. The failure to wait at least 1 minute between puffs resulted in medication error #2.

b. Medical record review for Resident #177 documented an admission date of 8/8/09 with diagnoses of Diabetes Mellitus with Peripheral Vascular Disease, Coronary Artery Disease and Ischemic Heart Disease, Hypertension and Cardiovascular Disease. Review of a physician's order dated 8/8/13 documented, "...ALBUTEROL INHALER 0.09... 2 PUFFS..."

Observations in Resident #177's room on 12/18/13 at 10:10 AM, revealed Nurse #8 administered two puffs of an Albuterol inhaler to Resident #177. Nurse #8 waited 20 seconds between puffs. The failure to wait at least 1 minute between puffs resulted in medication error #3.

**F 333 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS**

The facility must ensure that residents are free of any significant medication errors.
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 1 of 7 (Nurse #6) medication nurses administered medications free of significant medication errors. Nurse #6 failed to administer insulin within the proper time frame related to meals for Resident #306.

The finding included:

Review of the facility's medication administration policy documented, "...Novolog: Snack or meal within 5-10 minutes of administering the insulin..."


Observations in Resident #306's room on 12/18/13 at 4:09 PM, revealed Nurse #6 administered 2 units of Novolog insulin to Resident #306. Resident #306's meal tray had not been delivered as of 5:35 PM, 1 hour and 26 minutes after administration of the insulin. This resulted in a significant medication error.

During an interview on the south hall, second
F 333
Continued From page 13
floor Birmingham on 12/18/13 at 5:10 PM, Nurse #6 was asked about the administration of Novolog insulin in relation to meal time. Nurse #6 stated, "...[Novolog insulin] should be given 30 minutes before meals...">

During an interview on the north hall, fourth floor Birmingham on 12/18/13 at 5:30 PM, Nurse #9 was asked about the administration of Novolog insulin in relation to meal time. Nurse #9 stated, "...Normally Novolog is given with meals..."

F 371 483.35(I) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on policy review, observation and interview, it was determined the facility failed to ensure food was not stored past the expiration date and failed to ensure food was dated when opened on 1 of 3 (12/16/2013) days of the survey.

The findings included:
Review of the facility's food storage policy documented, "...it is our policy to prepare and store food that is stored in accordance with

A. December 17, 2013 and December 18, 2013 the Director of Food and Nutrition and the Dietary Manager inspected all department food storage areas to assure all foods were Covered, Dated and Labeled (CDL) and within expiration date.

December 23, 2013 all dietary supervisors were instructed on F-tag 371, including information on Cover, Date and Label (CDL) and First In First Out (FIFO). (See Attachment X)

December 26, 2013 dairy company contacted by Dietary Manager to establish an understanding on rotation of all dairy products and establish an area in the dairy cooler "Do Not Use Expired" to identify products that are to be returned for credit.
F 371 Continued From page 14

   federal, state, and local sanitary codes...
   Procedure... 2. Refrigerator... d. Raw meats,
   poultry, and fish will be wrapped labeled, and
   dated... f. Milk will be rotated with each delivery...
   Milk with the earliest expiration date will be used
   first... 4... a. All leftovers will be properly sealed...
   labeled, and dated..."

Observations in the kitchen on 12/16/13 at 11:15
AM revealed the following:
   a. Dairy cooler had two eight ounce cartons of fat
   free milk and a gallon of buttermilk stored past
   the expiration date of 12/13/13.
   b. Dairy cooler had a quart of heavy whipping
   cream with a manufacturer's use-by date of
   12/15/13 with a hand-written label stating, "Use
   by 11/23/13,"
   c. Meat cooler had an opened container of
   chicken bacon with no date when it was opened.
   d. Produce cooler had an opened, undated
   container of pimento and cheese spread that was
   not dated when it was opened.

During an interview in the kitchen on 12/17/13 at
11:15 AM, the Registered Dietician (RD) was
asked about the opened and undated container of
chicken bacon. The RD stated, "I'll throw that
away."

During an interview in the kitchen on 12/17/13 at
9:45 AM, the Dietary Manager (DM) was asked
about the expired milk products. The DM stated,
"We use a crate specifically for outdated milk in
the dairy cooler, so it can be returned to the
vendor for credit." These items were not in the
expired crate. The DM asked if these items
got missed. The DM stated, "Yes."

F 431 483.60(b), (d), (e) DRUG RECORDS.

January 2, 2014 additions made to
DLT rounds guide to increase the
number of inspections of CDL.

January 8, 2014 dairy company
sent letter to confirm expectations
on delivery and rotation of product.
(See Attachment Y)

B. The dietary policies on Food
Storage and on Receiving Food
were updated to reflect FIFO and
CDL. (See Attachment Z)

C. By January 17, 2014 all dietary
personnel will be required to
complete in-service training on the
updated Food Storage and
Receiving Food policies with return
demonstration on rotating stock and
CDL. (See Attachment Z)

Learning objectives:
- Understand proper cover, date and label procedures
  for food storage
- Understand proper rotation of stock to assure
  food safety, FIFO
F 371 Continued From page 14

federal, state, and local sanitary codes...

Procedure... 2. Refrigerator... d. Raw meats, poultry, and fish will be wrapped labeled, and dated... f. Milk will be rotated with each delivery...

Milk with the earliest expiration date will be used first... 4... a. All leftovers will be properly sealed... labeled, and dated..."

Observations in the kitchen on 12/16/13 at 11:15 AM revealed the following:

a. Dairy cooler had two eight ounce cartons of fat free milk and a gallon of buttermilk stored past the expiration date of 12/13/13.

b. Dairy cooler had a quart of heavy whipping cream with a manufacturer's use-by date of 12/15/13 with a hand-written label stating, "Use by 11/23/13."

c. Meat cooler had an opened container of chicken bacon with no date when it was opened.

d. Produce cooler had an opened, undated container of pimento and cheese spread that was not dated when it was opened.

During an interview in the kitchen on 12/16/13 at 11:15 AM, the Registered Dietician (RD) was asked about the opened and undated container of chicken bacon. The RD stated, "I'll throw that away."

During an interview in the kitchen on 12/17/13 at 9:45 AM, the Dietary Manager (DM) was asked about the expired milk products. The DM stated, "We use a crate specifically for outdated milk in the dairy cooler, so it can be returned to the vendor for credit." These items were not in the expired crate. The DM was asked if these items got missed. The DM stated, "Yes."

F 431, 483.60(b), (d), (e) DRUG RECORDS,
The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

Based on policy review, observation and
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interview, it was determined the facility failed to ensure medications were stored properly as evidenced by a Heparin syringe laying on top of a medication cart, internal medications stored with external medications and disinfectant wipes and medications not dated when opened in 3 of 26 (Birmingham 2 south hall medication cart, Birmingham 3 north hall medication cart and Birmingham 2 north medication cart) medication storage areas.

The findings included:

1. Review on the facility's medication storage policy documented, "...C. Orally administered medications are kept separate from externally used medications, such as suppositories, liquids, and lotions... F. Except for those requiring refrigeration, medications intended for internal use are stored in medication cart... H. Potentially harmful substances (such as... disinfectants)... stored in a locked area separately from medications..."


During an interview on Birmingham 2 south hall on 12/17/13 at 11:39 AM, Nurse #1 was asked what was in the syringe and what should have been done concerning the syringe of Heparin laying on the medication cart. Nurse #1 stated, "...Heparin... should have drawn it up when ready to take the rest of the medicines in [to the resident]..."
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During an interview in the Birmingham 2 nurse manager's office on 12/17/13 at 12:08 PM, Nurse #2 was asked what should the nurse have done with the syringe left laying on the medication cart unattended. Nurse #2 stated, "...Would have expected [Nurse #1] to put it back in the cart and lock it up..."

During an interview in the Director of Nursing's (DON) office on 12/18/13 at 5:20 PM, the DON was asked where would she expect Heparin injection to be stored. The DON stated, "...in the med [medication] cart...

3. Observations on Birmingham 3 north hall on 12/17/13 at 2:20 PM, revealed the Birmingham 3 north hall medication cart had packaged Ibuprofen tablets stored in a box with antibiotic ointment packets, an unlabeled suppository stored with Acetaminophen tablets, 4 containers of Sani-Hands wipes stored in a drawer with liquid medications.

During an interview on the Birmingham 3 north hall on 12/17/13 at 2:35 PM, Nurse #4 stated in regards to the Sani-Hands wipes "...they're not open..."

During an interview in the Director of Nursing's (DON) office on 12/18/13 at 5:20 PM, the DON was asked where would she expect Heparin injection to be stored. The DON stated, "...in the med [medication] cart..."

4. Observations on the Birmingham 2 north hall on 12/17/13 at 2:45 PM, revealed the Birmingham 3 north hall medication cart contained Pyrazinamide and Vasolex ointments that were not dated when opened.
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During an interview on Birmingham 2 north hall on 12/17/13 at 2:55 PM, Nurse #5 was asked if the medication should be dated when opened. Nurse #5 stated, "...I would assume so, everything that has been opened would need a date..."

During an interview in the DON's office on 12/18/13 at 5:20 PM, the DON was asked if multiple dose medications should be dated when opened. The DON stated, "...would expect it to be dated...

F 441: 483.66 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
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 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

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

 This REQUIREMENT is not met as evidenced by:
 Based on policy review and observation, it was determined the facility failed to ensure 1 of 7 (Nurse #10) medication nurses failed to change gloves between administering eye drops into Resident #247's eyes to prevent the potential spread of infection or cross contamination.

 The findings included:

 Review of the facility's "Med Pass Technique" documented, "...change gloves in between each eye drop administration...."

 Observations in Resident #247's room on 12/17/13 at 2:32 PM, Nurse #10 administered eye drops in one of Resident #247's eyes. Nurse #10 did not wash hands or change gloves before administering eye drops into Resident #247's other eye.

 LEARNING OBJECTIVES:

- Understanding the importance of correctly washing hands when instilling eye drops
- Understanding all steps involved to accurately instill eye drops into both eyes for a resident

D. The PCM, Charge Nurse or Director of Quality/Risk Management will perform med pass audits which includes Eye Drops Administration (See Attachment DD) on 20% of all licensed nurses for at least 3 months. The threshold for compliance for the Quality Improvement process will be set at < 5%. Once threshold is met for three (3) consecutive months, audits will be conducted at the discretion of the DON or Director of Quality/Risk Management. Audit results will be reported monthly in Quality Council Committee.