F 164 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. But this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution, or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
- Based on policy review, observation and interview, it was determined the facility failed to ensure 1 of 7 (Nurse #3) nurses provided full visual privacy while providing care.

1) Upon being made aware of Nurse #3 deficient practice of not pulling the curtain while providing wound care to the patient, a one on one in-service was conducted with nurse #3 on providing privacy by closing door and curtains when providing wound care to a resident. This was done on 6-19-13.

2) On 6-21-13 DON and/or designee observed Wound Care Nurse providing care to other residents with wounds to ensure privacy is provided. Observation will continue until substantial compliance is met.

On 6/26/13 and 6/27/13 the DON conducted an in-service to all nursing staff (RN, LPN, CNA) on closing door and pulling privacy curtain while providing care. The “Quality of Life- Dignity” policy was due to each nursing employee on 6-26-13 and 6-27-13.
F 164. Continued From page 1

The findings included:

Review of the facility's "Quality of Life--Dignity" policy documented, "...Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment or medication procedures..."

Observations in Resident #163's room on 6/10/13 at 9:30 AM, a surveyor knocked on the door, heard "come in" from Nurse #3 inside the room, opened the door and saw Resident #163 fully exposed. The privacy curtain was not pulled around Resident #163's bed to provide full visual privacy.

Observations in Resident #163's room on 6/11/13 at 9:05 AM, Nurse #3 did not pull the privacy curtain around the bed while providing wound care to Resident #163. During the wound care treatment, a dietary staff member knocked on the door and entered the room which exposed Resident #163.

During an interview in the family room on 6/12/13 at 8:40 AM, the Director of Nursing (DON) was asked what would she expect from staff to ensure privacy was provided during a treatment. The DON stated, "...shut the door, pull the curtain...it [privacy curtain] should be pulled all the way..."

During an interview in the family room on 6/12/13 at 9:05 AM, Nurse #3 was asked about his routine for providing privacy during care of residents. Nurse #3 stated, "...give them [residents] some privacy... pull the curtain..." Nurse #3 confirmed he failed to pull the curtain.

Any nursing employee not attending the mandatory in-service will not be allowed to work until they have attended the in-service.

3) Beginning 7-1-13, the DON or designee will randomly observe the Wound Care Nurse monthly to ensure facility policy is followed with no violations to the privacy of residents when care is provided. The Wound Care Nurse will report weekly to the DON acknowledging the observance of the privacy policy while providing care to residents for the next 3 months.

4) The DON will report the monitoring outcomes of privacy concerns to the next quarterly QAPI Committee and ultimately the Administrator will report to the Governing Board quarterly.
F 164: Continued From page 2
around Resident #163's bed and provide full
visual privacy during treatment on 6/11/13 and
6/12/13.

F 371: 483.35(i) FOOD PROCURE,
SS=E: 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 prepared, stored or served
under sanitary conditions on 2 of 3 (6/9/13 and
6/10/13) days of kitchen observations.

The findings included:

1. Review of the facility's "Sanitization" policy
documented, "...Policy Interpretation and
Implementation... All kitchens, kitchen areas
dining areas shall be kept clean, free from litter
and rubbish... All utensils, counters, shelves and
equipment shall be kept clean, maintained in
good repair and shall be free from breaks,
corrosions, open seams, cracks and chipped
areas that may affect their use or proper
cleaning... Kitchen and dining room surfaces not
in contact with food shall be cleaned on a regular

1) Upon receiving the survey
deficiencies on 6-9-13, the
Administrator met with the
Dietary Manager, Chief
Administrative Officer for
Dietary Services, to review the
deficiencies and regulatory
requirements. The
Administrator requested an
action plan for terminal cleaning
of the Dietary Department by 6-
21-13.

On 6-19-13, the Administrator
met with the Dietary Manager
and Chief Administrative
Officer for Dietary Services to
review the deficient practices in
the Dietary Department. The
following actions were
developed to ensure appropriate
cleaning of the environment and
equipment and proper storage of
food in the Dietary Department.

- On 6-26-13 the Dietary
Manager provided in-servicing
to the dietary staff and Chief
## Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>Provider/Supplier/Clinical Identification Number</th>
<th>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>445378</td>
<td>(each deficiency must be preceded by full regulatory or LSC identifying information)</td>
<td>(each corrective action should be cross-referenced to the appropriate deficiency)</td>
</tr>
</tbody>
</table>

### F 371 Continued From page 3

Schedule and frequently enough to prevent accumulation of grime... Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment...

2. Observations during the initial tour of the kitchen on 6/9/13 at 10:45 AM revealed the following:

a. A build up of ice on the ceiling and floor and water dripping from the ceiling of the freezer.
b. A 3 ounce container of vanilla ice cream was sitting on the floor underneath the shelf along with frozen food droppings and unswept trash on the floor underneath the storage shelves.
c. A pork loin was thawing, with juice dripping on top of a box in the back of the refrigerator.
d. Empty boxes were stacked on the floor approximately 4 feet high next to the kitchen garbage can.
e. Bread crumbs, sliced tomatoes, and crumbs of food were on the floor in the dish wash room and stove area.
f. Crumbs and food particles were on the floor in front of the stove and on the stove top.
g. Broiler oven located on the shelf over the stove had a missing door which revealed a baking rack with brown carbon colored substance. The bottom of the broiler had a build up of grease, dust and bread crumbs.

### Administrative Officer for Dietary Services on procedures for daily cleaning at the end of the day, chemicals to use and techniques to use.

- On 6-21-13 the Dietary Manager established observation and monitoring criteria for the dietary department to include the cleaning and disinfection process for equipment and environment. The Dietary Manager will make visits weekly beginning 6-24-13 for 3 months, then monthly. After substantial compliance has been acquired, visits from the Dietary Manager will be done randomly on a quarterly basis.

- Policies reviewed and revised: Kitchen Sanitation (please see the attached)

- Beginning 6-26-13 Mandatory in-services will be conducted monthly by the Dietary Manager for all dietary staff concerning the deficient practices, changed policies, and monitoring tools established. These in-services
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>445378</td>
<td>A. BUILDING</td>
</tr>
<tr>
<td></td>
<td>B. WING</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

WOODCrest AT BLAKEFORD

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

11 BURTON HILLS BLVD
NASHVILLE, TN 37215

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LTC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 371</td>
<td>Continued From page 4 dishwasher room. i. The rubber splash guard was broken on the garbage disposal, leaving it open. m. Kitchen floor was wet and slippery with dropped food particles next to stove area.</td>
<td>F 371</td>
<td>will be conducted for 6 months. Specific topics and objective will be stated for each in-service conducted.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Observations in the kitchen on 6/9/13 at 3:30 PM revealed the following: a. Three 9 inch frying pans on the shelf over the stove were covered with black carbon. b. A brown substance dripping on the floor beside the deep fryer. c. There was a grease residue and crumbs on the rim of the deep fryer. d. Crumbs and scraps of food were on the floor around the stove and on the stove top. f. Broiler oven located on the shelf over the stove had a missing door which revealed a baking rack with brown carbon colored substance. The bottom of the broiler had a build up of grease, dust and bread crumbs. g. Stove top had a black build up around the edges. h. Water was leaking on the floor from the steamer door leaving a pool of water on the floor. i. Baking rack from the food warmer was on the floor next to the warmer. j. There was a dust and dirt behind and underneath the stove and the deep fryer. k. The rubber splash guard was broken on the garbage disposal leaving it open. l. The kitchen floor was wet, slippery and food particles on the floor next to the stove area. m. White liquid on the floor in dishwasher room underneath the garbage disposal. n. Water leaking on the floor and underneath the sink from the garbage disposal pipes. o. A build up of ice on ceiling and floor and water will be conducted for 6 months. Specific topics and objective will be stated for each in-service conducted.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2) On 6-20-13 the Dietary Manager established a cleaning schedule and a monitoring tool to ensure timely and adequate cleaning of each deficient practice stated in the 2567 – a build up of ice on the ceiling and floor, ice cream container on floor underneath the shelf along with food droppings and unswept trash on floor, pork loin thawing and dripping on top of box in the back of refrigerator, empty boxes stacked on the floor, bread crumbs, sliced tomatoes, and crumbs of food on the floor in the dish wash room and stove area, missing door on the shelf over the stove which reveals brown carbon colored substance, bottom of boiler had a build-up of grease, dust and bread crumbs, crumbs, dried food and liquid red colored spillage in the drip pans of the stove, stove top had a black build up around the stove</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Id</td>
<td>F 371</td>
<td>Continued From page 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----</td>
<td>-------</td>
<td>-----------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>p.</td>
<td>A 3 ounce container of vanilla ice cream, frozen food particles and unswept trash were on the floor underneath the storage shelves.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Observations in the kitchen on 6/10/13 at 3:30 PM revealed the following:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td>A black substance build up was on all 4 wheels of the deep fryer.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>A large baking pan on top of the warmer had carbon build up on the sides and on the bottom.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>The kitchen floor was wet, slippery, and food particles were next to the stove area.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>Water was leaking from the pipes and around the bottom of the garbage disposal.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td>The rubber splash guard was broken on the garbage disposal, leaving it open.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>During an interview in the kitchen on 6/10/13 at 3:30 PM, the Registered Dietician (RD) was asked about the food and trash on the floor. The RD stated, &quot;...Is there a problem... We do our cleaning on Sunday and Sunday nights...&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>During an interview on the L hall on 6/12/13 at 9:45 AM, the Administrator was asked if she expected the kitchen to be clean. The Administrator stated &quot;...I expect the kitchen to be clean at all times...&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Id</td>
<td>F 431</td>
<td>483.80(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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</td>
<td>1) Upon becoming aware of the expired vial of insulin on 6-11-13, nurse #1 immediately discarded the vial of insulin. All the nurses (RN, LPN) working on M hall involved in using the expired insulin received one on</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
with brown carbon colored substance, stove top had a black build up around the eyes, water leaking on the floor from the steamer door leaving a pool of water on the floor, baking rack from the food warmer was on the floor, dust and dirt behind and underneath the stove and deep fryer, rubber splash guard was broken on the garbage disposal leaving it open, white liquid on the floor in dishwasher room underneath the garbage disposal, water leaking on the floor and underneath the sink from the garbage disposal pipes, build up of ice on ceiling and floor in dripping from ceiling in the freezer, ice cream container on floor underneath shelf, unswept trash on floor underneath the storage shelves. Deficient practice on 3rd day of observations -- black substance build up on all 4 wheels of the deep fryer, large baking pan on top of the warmer had carbon build up on the sides and on the bottom, kitchen floor was wet, slippery and food particles next to the stove area, water leaking from the pipes and around the bottom of the garbage disposal, rubber splash guard broken on the garbage disposal leaving it open. (Attachment)

On 6-19-13 the Dietary Manager completed a maintenance request to repair the garbage disposal, water leak from the steamer, and check the water leak in the walk-in freezer. All issues will be repaired by 7-20-13.

A new fryer was ordered on 6-25-13.

The stated missing broiler door is not missing. The broiler/salamander originally does not have a door.

3) To ensure the deficient practice does not reoccur, beginning 6-19-13 the Chief Administrative Officer for Dietary Services will begin checking Dietary Services weekly for three months then monthly until substantial compliance has been obtained with the cleaning policies. The Dietary Manager will establish a monitoring form for staff to complete after cleaning their area each day. The Dietary Manager will initial the monitoring form daily upon observance of the cleanliness of the department and compliance of the monitoring tool. Any issues identified will be evaluated, investigated and an action plan put into place immediately and reported to the Administrator..

4) The Dietary Manager will report monitoring outcomes at every meeting of the QAPI Committee. The next meeting of the QAPI Committee is July, 2013. The Administrator will report all monitoring outcomes at the next Governing Body Meeting.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/Clinical Laboratory Improvement Amendments (CLIA) Identification Number: 445378

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 
B. WING

(X3) DATE SURVEY COMPLETED
06/12/2013

NAME OF PROVIDER OR SUPPLIER
WOODCREST AT BLAKEFORD

STREET ADDRESS, CITY, STATE, ZIP CODE
11 BURTON HILLS BLVD
NASHVILLE, TN 37215

(X4) ID PREFIX : (X5) COMPLETION DATE
TAG 
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR CLIA IDENTIFYING INFORMATION)

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

F 431 Continued From page 6
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 interview, it was determined the facility failed to ensure medication was stored properly by failing to discard medication within the accepted discard time in 1 of 10 (M hall medication cart) storage areas.

The findings included:

one counseling concerning the importance of checking the expiration date of medication prior to medication administration.

On 6-26-13 and 6-27-13 the DON conducted an in-service to all licensed nursing staff (RN, LPN) on dating multi-dose vials when opened. The "Administration of Medication" policy was given to each nursing employee on 6-26-13 and 6-27-13.

Any licensed nursing employees not attending the mandatory in-services will not be allowed to work until they have attended the in-service.

2) Beginning 6-24-13 the DON and/or designee checked the medication carts to ensure all multi-dose vials were dated for 28 day expiration. There were no other multi-dose vials incorrectly labeled.

Pharmacy staff will continue to conduct monthly med pass observations, med cart and med room checks and will submit outcomes to DON and QAPI Committee.
F 431  Continued From page 7

Review of the "Insulin Administration" policy documented, ". . . 4. Check expiration date . . . record opening date on the vial - facility policy is 28 days for expiration."

Observations of the M Hall medication cart, at the nurses station on 6/11/13 at 4:20 PM, revealed a 10 milliliter vial of Lantus insulin with an open date of 4/30/13. The vial should have been discarded 28 days (5/28/13) after it was opened.

During an interview at the nurses station on 6/11/13 at 4:20 PM, Nurse #1 was asked when the opened insulin vial should have been discarded. Nurse #1 stated, "Supposed to discard after 28 days."

F 441 483.85 INFECTION CONTROL, PREVENT SS=D 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

3) To ensure the deficient practice does not recur, the DON and/or designee will begin on 7-1-13 checking medication carts on a weekly basis for 8 weeks, then randomly on a monthly basis for any multi-dose vials with incorrect dates.

4) DON will report monitoring outcomes at every meeting of the QAPI Committee. The next meeting of the QAPI Committee is July 2013. The Administrator will report all monitoring outcomes at the next Governing Body Meeting.

1) After being informed by state surveyors on 6-9-13 that Nurse #2 improperly discarded a lancet in the trash can instead of the sharps container. The DON conducted a one on one in-service with Nurse #2 on 6-9-13 to ensure compliance with facility policy concerning disposal of sharp objects.

On 6-26-13 and 6-27-13 the DON conducted an in-service to all licensed nursing staff (RN, LPN) on proper disposal of sharps. The "Disposal of
F 441: Continued From page 8  

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 infection.  

This REQUIREMENT is not met as evidenced by:  

Based on policy review, observation and interview, it was determined 1 of 7 (Nurse #2) nurses failed to take precautions in the disposal of disposable equipment.  

The findings included:  

Review of the "...Medical Waste, Handling..." policy documented, "...2. All sharps must be handled as medical waste, placed in approved sharps containers, and sent for eventual incineration..."  

Observations on the K hall on 6/9/13 at 11:55 AM, Nurse #2 removed his gloves with a lancet inside and threw the gloves with the lancet inside in the trash can in the medication room.  

Sharps’ policy was given to each nursing employee on 6-26-13 and 6-27-13.  

Any licensed nursing employees not attending the mandatory inservices will not be allowed to work until they have attended the in-service...  

2) Beginning 6-20-13 the DON and/or designee observed all licensed nursing staff during medication pass to ensure proper disposal of sharps in the appropriated container. This will be completed on 7-01-13. There were no other staff disposing of sharps incorrectly.  

3) To ensure the deficient practice does not recur, the DON and/or designee will conduct a monthly in-service on OSHA requirement for handling sharps and sharps disposal. Any nurse that continues deficient practice will be disciplined by the DON.
<table>
<thead>
<tr>
<th>F 441</th>
<th>Continued From page 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>During an interview in the family room on 6/12/13 at 10:40 AM, the Director of Nursing (DON) was asked what should have been done with the used lancet. The DON stated, &quot;It should have been discarded in a sharps container.&quot;</td>
<td>F 441</td>
</tr>
</tbody>
</table>