**F 272 483.20(b)(1) COMPREHENSIVE ASSESSMENTS**

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:
- Identification and demographic information;
- Customary routine;
- Cognitive patterns;
- Communication;
- Vision;
- Mood and behavior patterns;
- Psychosocial well-being;
- Physical functioning and structural problems;
- Continence;
- Disease diagnosis and health conditions;
- Dental and nutritional status;
- Skin conditions;
- Activity pursuit;
- Medications;
- Special treatments and procedures;
- Discharge potential;
- Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and
- Documentation of participation in assessment.

1.) All residents will have an accurate assessment in accordance with RAI manual guidelines.

2.) Resident #92's October and January assessment was corrected and to reflect correct and current diagnoses in section 1. Corrected MDS was transmitted on 3/23/12.

3.) As the MDS Coordinator populates new assessments in the computer system, all checked diagnoses will be wiped clear from section I of the MDS. The MDS Coordinator will then mark item 12300 for a look-back period of 30 days using the specific criteria in the RAI manual.

- Code only if all of the following are met:

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

**DATE**

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of the survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>F 272</td>
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This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to accurately assess 1 of 11 (Resident #92) sampled residents reviewed of the 24 residents included in the Stage 2 review.

The findings included:

Medical record review for Resident #92 documented an admission date of 1/4/11 with diagnoses of Congestive Heart Failure, Osteoporosis, Atrial Fibrillation, Coronary Atherosclerosis, Depressive Disorder, Hyperlipidemia, Generalized Muscle Weakness, Abnormal Urine Findings and Failure to Thrive. Review of the Minimum Data Set dated 10/26/11 and 1/23/12 documented, "...I 2300- UTI Urinary Tract Infection in last 30 days..." There was no documentation Resident #92 had a Urinary Tract Infection during those assessment times.

During an interview in the conference room on 3/14/12 at 3:45 PM, the Minimum Data Set (MDS) Coordinator stated, "...Could not find any documentation of a UTI. The new system prepopulates old information and I just did not remove it. She [Resident #92] has not been treated for UTI's..."

During an interview at the L nurses station on 3/14/12 at 4:05 PM, the Nurse Practitioner stated, "She [Resident #92] has not had a urinalysis since 2/11 [February 2011] and it was negative."

- a. Physician, nurse practitioner, physician assistant, or clinical nurse specialist or other authorized licensed staff as permitted by state law diagnosis of a UTI in last 30 days,

- b. Sign or symptom attributed to UTI, which may or may not include but not be limited to: fever, urinary symptoms (e.g., peri-urethral site burning sensation, frequent urination, of small amounts), pain or tenderness in flank, confusion or change in mental status, change in character of urine (e.g., pyuria),

- c. "Significant laboratory findings"

- d. Current medication or treatment for a UTI in the last 30 days.
**F 272** Continued From page 1

This **REQUIREMENT** is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to accurately assess 1 of 11 (Resident #92) sampled residents reviewed of the 24 residents included in the Stage 2 review.

The findings included:

Medical record review for Resident #92 documented an admission date of 1/4/11 with diagnoses of Congestive Heart Failure, Osteoporosis, Atrial Fibrillation, Coronary Atherosclerosis, Depressive Disorder, Hyperlipidemia, Generalized Muscle Weakness, Abnormal Urine Findings and Failure to Thrive. Review of the Minimum Data Set dated 10/26/11 and 1/23/12 documented, "...I 2300- UTI [Urinary Tract Infection] in last 30 days,..." There was no documentation Resident #92 had a Urinary Tract Infection during those assessment times.

During an interview in the conference room on 3/14/12 at 3:45 PM, the Minimum Data Set (MDS) Coordinator stated, "...Could not find any documentation of a UTI. The new system prepopulates old information and I just did not remove it. She [Resident #92] has not been treated for UTI's..."

During an interview at the L nurses station on 3/14/12 at 4:05 PM, the Nurse Practitioner stated, "She [Resident #92] has not had a ua [urinanalysis] since 2/11 [February 2011] and it was negative."

**F 272**

4.) All residents who had UTI diagnosis marked since assessments date of 01/01/2012 were reviewed for correct coding using the RAI manual criteria on 3/16/12. No other residents were found to be coded incorrectly at that time.

The MDS Coordinator will monitor all UTI’s that are marked on MDS assessments for accuracy according to RAI guidelines on a monthly basis and reported to QI committee beginning with April 2012 meeting. Frequency of continued monitoring will be re-assessed at the 3rd quarterly QA meeting in October 2012. Dual evaluation by the QA committee, as well as the MDS coordinator, will be assessed at that time as to the continued need of monitoring, or if a change in reporting frequency is necessary.
1. All residents will have revised comprehensive care plan that reflects resident's needs.

2. Upon becoming aware that Resident #112's care plan did not reflect the Ensure being received at meal time, the MDS Coordinator and the Licensed Dietitian updated resident #112's care plan. (See attached #5)

3. All residents were checked by the Dietitian to make sure no other residents were receiving Ensure that had not been care planned. This was completed on 3/16/12. No other residents had orders for Ensure that had not been care planned.

4. The Director of Nursing, Dietitian, and MDS Coordinator will evaluate residents on a monthly basis to determine who may need Ensure. The care plan would be updated at this review to reflect their needs. The Dietitian and/or designee will evaluate the monitoring frequency after 6 months of monthly reviewing if the frequency needs to be changed.
### F 280
**Continued From page 3**

Care plans are revised as information about the resident and the resident's condition change...

Medical record review for Resident #112 documented an admission date of 4/15/11 with diagnoses of Aphasia, Dysphagia, Diabetes Type II, Peripheral Vascular Disease, Coronary Artherosclerosis and Depressive Disorder. Review of the Interdisciplinary Notes dated 1/23/12 documented, "[three times daily] with meals." Review of a physician's order dated 2/22/12 documented, "...BEVERAGE ...chocolate ENSURE..." Review of the comprehensive care plan for nutritional status dated 2/3/12 was not revised to include the nutritional supplement.

Observation in Resident #112's room on 3/13/12 at 6:15 PM, revealed Resident #112 drinking an Ensure supplement.

During an interview at the J/M nurse's station on 3/13/12 at 6:25 PM, the Registered Dietician (RD) was asked if Resident #112 receives a nutritional supplement. The RD stated, "Yes, he gets it with meals." The RD was asked if the nutritional supplement was on the care plan. The RD reviewed the current care plan and stated, "It hasn't been updated. It's not on there..."

### F 309
**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

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5. The Dietitian will report to the quarterly QA committee meeting the outcomes of the monitoring of the care planning of resident receiving Ensure. The reporting of the outcomes will begin at the April 2012 QA meeting and quarterly thereafter.

1. All residents will receive the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being. All residents who need hospice care will have a current physician order.
F 309 Continued From page 4 accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review and interview, it was determined the facility failed to have a current physician’s order for receiving hospice care or failed to follow the facility’s policy and physician’s orders for lack of having a bowel movement (BM) for 2 of 11 (Residents #54 and Resident #152) sampled residents reviewed of the 24 residents in the Stage 2 review.

The findings included:

1. Review of the facility’s "Medication Orders and Treatment, Hospice Services" policy documented, "...Orders for the treatment of the resident's in hospice must be signed by the Attending Physician..."

Medical record review for Resident #54 documented an admission date of 3/29/11 with diagnoses of Aortic Valve Disorders, Benign Hypertension, Diastolic Heart Failure, Atrial Fibrillation, Dementia, Acute Respiratory Failure, Acute Renal Failure, End Stage Chronic Airway Obstruction and Methicillin Resistant Staphylococcus Aureus Pneumonia. There was no physician order to admit Resident #54 to Hospice care. Review of the "Entrance Conference Worksheet" completed by [Named Facility], documented Resident #54 as a resident of Hospice.

F 309 for receiving hospice care and residents who need assistance with a bowel movement, a physician orders will be provided by use of standing bowel protocol orders.

2. Upon becoming aware that the hospice order for resident # 54 was not in the electronic record system (AOD), the Director of Nursing entered the order into AOD on 3/14/12. (See Attachment #1)

On 3/23/12 the administrator sent a memo to all Hospice providers stating that they must have an order from the residents’ attending physician prior to providing any services to residents at Woodcrest. (See Attachment #2)

On 3/20/12 a standing order for Hospice care was entered into the electronic medical record system (AOD) in the physician order library under the Social Services heading that will assist nurses with transcribing orders by allowing them to select pre-typed physician order from a library of standing orders. (See Attachment #3)
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>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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<td>F 309</td>
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<td>On 3/14/12 the Director of Nursing interviewed resident and resident’s wife to assess the need of a laxative since there were more than 3 days since last BM. Resident did not need any intervention for a bowel movement. On March 19, 2012 the BM protocol was entered into the electronic medical record system under the physician order Library for nurses to use when entering orders into the electronic order systems. The Physician Order Library allows the user to transcribe a list of commonly used orders with a minimum of data entry. (See Attachment #4)</td>
<td>3/14/12</td>
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<td>During an interview at the L wing nurses station on 3/13/12 at 5:30 PM, Nurse #2 was asked how long Resident #54 had been receiving Hospice care. Nurse #2 stated, &quot;She has been having Hospice care since she has been on this floor and I don’t know when she came but it has been months ago. Nurse #2 was then asked if there was a current order for Hospice services. Nurse #2 stated, &quot;No ma’am...&quot;</td>
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<td>During an interview in the conference room on 3/14/13 at 8:00 AM, the Director of Nursing (DON) was asked if the facility requires an admit order for Hospice care. The DON stated &quot;Yes.&quot; The DON was asked for the orders to admit Resident #54 to Hospice care. The DON stated, &quot;I have not found that order...&quot;</td>
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<td>3/14/12</td>
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<td>2. Review of the facility's &quot;BM Tracking&quot; policy documented, &quot;...The CNT [Certified Nursing Technician] will record any bowel and bladder activity in the electronic medical record every shift... The licensed nurse will check the report for recorded bowel movements at the start of each shift to determine if a laxative, suppository or enema is necessary. BM protocol will be followed after 3 days, as outlined in standing physician orders... Bisacodyl...Dulcolax) 10 mg; insert 1 suppository (s) (10mg) by rectal route as needed for constipation, if no results, see enema order...&quot;</td>
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<td>3/16/12</td>
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<td>Medical record review for Resident #152 documented an admission date of 12/21/11 with diagnoses of Muscle Weakness, Urinary Tract Infection, Altered Mental Status, Insomnia, Chronic Kidney Disease Stage III, Depressive Disorder and Organic Brain Syndrome. Physician's orders dated 12/26/11 and updated</td>
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<td>3/16/12</td>
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F 309 Continued From page 6
3/2012 documented, ". . . BISACODYL TABLET 10 MG [milligram] QD [every day] PRN [as needed] CONSTIPATION . . . " Resident #152's December 2011 "Point of Care Daily Charting" for bowel movements had no BM documented from 12/21/11 through 12/26/11. Resident #152's December 2011 Medication Administration Record (MAR) documented Bisacodyl 10 mg was not given until 12/26/11. Resident #152's January 2012 "Point of Care Daily Charting" had no BM documented from 1/13/12 through 1/18/12. There was no documentation of a medication or an intervention put in place for lack of a BM from 1/13/12 through 1/18/12. Resident #152's February 2012 "Point of Care Daily Charting" for BM documentation had no BM documented from 2/5/12 through 2/10/12. There was no documentation of an intervention put in place for lack of a BM from 2/5/12 through 2/10/12.

During an interview in the conference room on 3/14/12 at 3:00 PM, the DON was asked about no documentation of BM or interventions for lack of Resident #152 having a BM. The DON stated, " . . . BM is not documented for Resident #152 . . . ."

During an interview at the 2nd floor nurses station on 3/14/12 at 4:00 PM Nurse #4 stated, "I'm sure Resident #152 had gone [had a BM] but they [BMs] weren't recorded."

F 371 483.35(f) FOOD PROCUREMENT, 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

4. Beginning 3/26/12, a daily BM monitoring tool was established for each nursing unit to track resident's BMs and use of BM protocol in AOD. The policy for BM documentation by CNTs and use of the BM protocol, when more than 3 days of no BMs documented in AOD is still the standard of performance expected by management. The monitoring tool will be used for 2 months by the charge nurses and will be evaluated by the Director of Nursing and Administrator for its continued use beyond 2 months. The Director of Nursing or designee will monitor a random sample of residents on each nursing unit on a weekly basis for accurate and complete documentation in AOD for 2 months then reduce to monthly monitoring until documentation practices are being carried out according to policy.

5. The Director of Nursing will report to the quarterly QA committee meeting.
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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 309</td>
<td>Continued From page 6 3/2012 documented, &quot;...BISACODYL TABLET 10 MG [milligram] QD [every day] PRN [as needed] CONSTIPATION...&quot; Resident #152's December 2011 &quot;Point of Care Daily Charting&quot; for bowel movements had no BM documented from 12/21/11 through 12/26/11. Resident #152's December 2011 Medication Administration Record (MAR) documented Bisacodyl 10 mg was not given until 12/26/11. Resident #152's January 2012 &quot;Point of Care Daily Charting&quot; had no BM documented from 1/13/12 through 1/18/12. There was no documentation of a medication or an intervention put in place for lack of a BM from 1/13/12 through 1/18/12. Resident #152's February 2012 &quot;Point of Care Daily Charting&quot; for BM documentation had no BM documented from 2/6/12 through 2/10/12. There was no documentation of an intervention put in place for lack of a BM from 2/5/12 through 2/10/12. During an interview in the conference room on 3/14/12 at 3:00 PM, the DON was asked about no documentation of BM or interventions for lack of Resident #152 having a BM. The DON stated, &quot;...BM is not documented for Resident #152...&quot; During an interview at the 2nd floor nurses station on 3/14/12 at 4:00 PM Nurse #4 stated, &quot;I'm sure Resident #152 had gone [had a BM] but they [BMs] weren't recorded.&quot;</td>
<td>the outcomes of BM documentation, use of bowel protocol and resident's who have hospice orders. The reporting of the outcomes will begin at the April 2012 QA meeting and quarterly thereafter.</td>
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| F 371 | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY | I. The facility will ensure that food is served under sanitary conditions. |

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
F 371 Continued From page 7 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 that food was served under sanitary conditions during 2 of 2 (Noon meal on 3/12/12 and Supper meal on 3/13/12) dining observations conducted in the woodcrest dining room and on K hall.

The findings included:

1. Review of the facility’s “Handwashing/Hand Hygiene” policy documented, “...1. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors... 5. Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions... c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice)... g. Before and after assisting a resident with meals... p. After blowing or wiping nose... 6. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% [percent] ethanol or isopropanol for all the following situations: a. Before and after direct contact with residents... i. After contact with objects (e.g., [for example] medical equipment) in the immediate vicinity of the resident...”

2. On 3/21/12 the Director of Nursing conducted an in-service with the K Hall staff including CNT #1 and CNT #2 concerning hand washing and reviewed deficiencies cited by surveyors. The hand hygiene policy was shared with all staff on 3/22, 3/23/12, 04/10/12 and 04/11/12. These in-services also addressed the practice of ensuring staff wash their hands between touching residents and use of hand disinfectant.

All wait staff that work in the dining room will be in-serviced by the Dietary supervisor on hand hygiene on 04/10/12 and 04/11/12.

3. The Director of Nursing or designee will observe serving of meal trays on each nursing unit on a random basis beginning April 2012. The Dietary Supervisor will observe wait staff hand hygiene techniques on a random basis beginning April 2012.

4. The Director of Nursing, Dietary Supervisor or designee will observe staff randomly on a monthly basis while serving meal trays in resident rooms and in the dining room for 3 months then as needed to ensure sanitary practices are provided by staff.
F 371 Continued From page 8

2. Observations of the noon meal in the woodcrest dining room on 3/12/12 from 12:05 to 12:20 PM, revealed Waitstaff #1 wiped his face on his right sleeve, moved a chair, then placed clean utensils on a table for a resident. Waitstaff #1 wiped his face with his hand, served fruit cups to several residents, served water to several residents, wiped his face again and served and opened applesauce to residents. Waitstaff #1 wiped his hands on his pants, served water and salads to residents, he then pulled up his shirt sleeve and served soup to several residents, he wiped his face with his hand again, moved a resident in a wheelchair, and continued to serve more soup and coffee to residents before he left the dining room at 12:20 PM. Waitstaff #1 never washed his hands or used hand gel.

Observations of the noon meal on the K hall on 3/12/12 at 12:27 PM, revealed Certified Nursing Technician (CNT) #1 moved Resident #131's feet from the wheelchair foot pedals, rubbed his legs, moved the over-bed table to the resident, moved the scoop plate, uncovered bowls, left room and answered a call light in another room, then went to meal cart and got ice. CNT #1 did not wash her hands.

During an interview at the K hall nurses' station on 3/12/12 at 2:40 PM, CNT #1 was asked did she clean her hands after each resident contact. CNT #1 stated, "No I didn't, and I came back and got ice after going to the other room to answer the light."

5. The Director of Nursing will report to the quarterly QA committee meeting the outcomes of in-services and observation of hand washing while serving meal trays. The Dietary Supervisor will report to the quarterly QA committee meeting the outcomes of in-services and observation of hand washing while serving meals in the dining. The reporting of the outcomes will begin at the April 2012 QA meeting and quarterly thereafter.
**Summary Statement of Deficiencies**

**Deficiency Description:**

F 371 Continued From page 9

place the meal tray on the over-bed table for the resident in Room 148. CNT #2 tucked the napkin on the resident, set the tray up, turned on the room light, then returned to the food cart and took the meal tray to the resident in Room 145, placed the tray on the over-bed table, turned the TV volume up, returned to the meal cart and delivered the meal to the resident in Room 152. CNT #2 placed the tray on the over-bed table, placed napkin on the resident, set the tray up and returned to the meal cart. CNT. #2 delivered the meal tray to the resident in Room 149 placed the meal tray on the over-bed table, placed the napkin on the resident, set up the tray, adjusted the resident's napkin and returned to the meal cart.

During an interview on K hall on 3/13/12 at 6:00 PM, CNT #2 was asked if she washed her hands between resident contact. CNT #2 stated, "I didn't wash my hands, and I don't remember if I used hand gel, I forgot to wash."

4. During an interview in the conference room on 3/13/12 at 8:40 PM, Director of Nursing (DON) stated, "Would expect staff to wash hands."

During an interview on the L hall on 3/14/12 at 10:45 AM, Waitsstaff #2 stated, "We were taught to wash hands anytime we touched our face, hair, anything dirty, after touching residents and things."

**Corrective Action:**

1. This facility will ensure that drugs and biologicals are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID** | **PREFIX** | **TAG** | **ID** | **PREFIX** | **TAG** | **SUMMARY STATEMENT OF DEFICIENCIES**
---|---|---|---|---|---|---
F 431 | | | F 431 | | | 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 interview, it was determined the facility failed to ensure medications were label with an expiration date or were not stored past their expiration date in 1 of 8 (L hall stat medication closet) medication bottles.

2. Upon being informed of the medications with no expiration date on the bottles and medications with expiration dates of 3/6/12, the charge nurse removed medication from the Stat box immediately and drugs were replaced by pharmacy services on 3/15/12.

3. All stat medications were checked by the consultant pharmacist for other expired medications. No other medications were found to be expired. This was completed on 3/15/12.

4. In-services on checking the expiration dates of medication on all drugs, either in the Stat Box or the medication cart were completed on 3/22/12 and 3/23/12 by the Director of Nursing and Administrator. The Director of Nursing, Consultant Pharmacist, and/or Administrator will audit the Stat box for expiration dates monthly for 6 months then the DON & Consultant Pharmacist will determine the frequency of monitoring at that time.
**F 431** Continued From page 11 storage areas.

The findings included:

Review of the facility's "Storage of Medications" policy documented, "...The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed..."

Observations in the L hall stat medication closet on 3/14/12 at 4:45 PM, revealed the following:

a. Two (2) bottles of Kaexylate with no expiration date.

b. Four (4) Hydrocodone/APAP 10/500 milligram (mg) tablets were stored past the expiration date of 3/6/12.

During an interview at the L hall nurses' station on 3/14/12 at 5:05 PM, Nurse #3 confirmed the 2 bottles of Kaexylate did not have expiration dates and the Hydrocodone/APAP tablets were expired.

**F 441**

**SS=D**

**483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS**

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -

(1) Investigates, controls, and prevents infections in the facility;

(2) Decides what procedures, such as isolation, should be applied to an individual resident; and

5. The Director of Nursing will report to the quarterly QA committee meeting the outcomes of the monitoring of the drugs in the Stat Box. The reporting of the outcomes will begin at the April 2012 QA meeting and quarterly thereafter.

1. The facility will 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.
2. On 3/22/12 and 03/23/12 the Director of Nursing conducted an all staff in-service on correct hand washing and when to wear gloves while passing medications. The nurse received a copy of the Hand Hygiene policy and the policy on Administering Medication.

The hand hygiene policy was reviewed with all staff on 3/22, and 3/23. These in-services also addressed the practice of ensuring staff wash their hands between touching residents and use of hand disinfectant.

3. The Director of Nursing, Consultant Pharmacist or designee will observe licensed nurses weekly for 4 weeks during med pass beginning April 2012. Licensed nurses will be observed quarterly by the Consultant Pharmacist or designee until satisfactory performance is obtained.
**F 441** Continued From page 13

Wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and running water under the following conditions... I. Upon and after coming in contact with a resident's intact skin, (e.g. [for example], when taking a pulse or blood pressure, and lifting a resident)... 8. The use of gloves does not replace handwashing/hand hygiene...

Medical record review for Resident #54 documented an admission date of 3/29/11 with diagnoses of Aortic Valve Disorders, Benign Hypertension, Diastolic Heart Failure, Atrial Fibrillation, Dementia, Acute Respiratory Failure, Acute Renal Failure, Methicillin Resistant Staphylococcus Aureus Pneumonia, and End Stage Chronic Airway Obstruction.

Observations during the medication pass in Resident #54's room on 3/14/12 beginning at 8:55 AM, revealed Nurse #3 preparing medications for administration. Nurse #3 did not wash her hands prior to preparing the medications for Resident #54. Nurse #3 came out of Room 150 with equipment (pulse oximeter and thermometer) used on another resident and did not wash her hands or use hand gel before preparation of medications for Resident #54. Nurse #3 stopped preparing medications, returned the already pulled medications back into the medication cart, went to Resident #54's room and proceeded to take Resident #54's blood pressure, pulse, respirations, temperature and oxygen saturation. Nurse #3 left the room and returned to the medication cart to prepare the medications. Nurse #3 did not wash her hands or use hand gel. Upon entering Resident #54's room, Nurse #3 donned gloves, adjusted the oxygen cannula

**F 441**

4. The Director of Nursing, Consultant Pharmacist or designee will observe Med Pass on different nursing units on a monthly basis to ensure continued compliance of infection control practices by all nursing staff.

5. The Director of Nursing will report to the quarterly QA committee meeting the outcomes of in-services and observation of hand washing while passing medications. The reporting of the outcomes will begin at the April 2012 QA meeting and quarterly thereafter.
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<td>on Resident #54's nose, removed one glove to summon a Certified Nursing Technician to assist pulling the resident up in the bed. Nurse #3 replaced the glove, pulled the resident up in the bed, changed her gloves, assisted Resident #54 with respiratory treatment by holding the cannister for Resident #54. Nurse #3 did not wash her hands prior to preparing medications for Resident #54 or between pulling Resident #54 up in bed and assisting with the breathing treatment.</td>
</tr>
</tbody>
</table>

During an interview beside the L Wing medication cart on 3/14/12 at 9:30 AM, Nurse #3 was asked when she wash her hands during medication administration. Nurse #3 stated "...I should have washed before breathing treatment..." |

During an interview in the conference room on 3/14/12 at 2:56 PM, the Director of Nursing (DON) was asked when nurses should wash their hands. The DON stated, "...the nurses are to wash between residents..." |