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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tbody>
<tr>
<td>F 280</td>
<td>SS-D</td>
<td>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</td>
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The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

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

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation and interview, it was determined the facility failed to revise the comprehensive care plan for interventions for incontinence, assistance with dressing, a pleasure diet of liquids and/or care for emergency bleeding for 5 of 24 (Residents #7, 10, 12, 16 and 17) sampled residents.

The findings included:

1. Medical record review for Resident #7 documented an admission date of 1/11/11 with diagnoses of Atrial Fibrillation, Chronic Kidney
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<tr>
<td>F 280</td>
<td>Continued From page 1</td>
<td>Disease, Dialysis Three times week, Heart Murmur, History Eosinophilia and Hypertension. Review of the care plan dated 1/24/11 documented, &quot;...Monitor access area for redness/pain and report. Do not take blood pressure in arm...&quot; The care plan did not address measures to be used for emergency bleeding from the access area. During an interview in the activity office on 1/26/11 at 9:10 AM, Nurse #2 confirmed that the care plan did not address measures for emergency bleeding. 2. Medical record review for Resident #10 documented an admission date of 12/8/09 with diagnoses of History of Cerebrovascular Accident, Diabetes Mellitus, Dysphagia, Seizure Disorder, Traumatic Brain Injury and Congestive Heart Failure. Review of a physician's order dated 12/19/10 documented, &quot;...Glucerna 1.5 at 55 cc [cubic centimeters] / [per] hr [hour] PT [per tube]. Review of the &quot;Speech Therapy Dysphagia Evaluation&quot; dated 7/8/10 documented, &quot;...Solids: NPO [nothing by mouth] ...Liquids: NPO... Pt [patient] @ [at] extreme risk for aspiration...&quot; Review of the comprehensive care plan reviewed 12/14/10 documented, &quot;...INTERVENTIONS ...Encourage pleasure diet of liquids... Encourage fluids... Diet full liquids for pleasure...&quot; Observations in room 218 on 1/24/11 at 9:10 AM, revealed Resident #10 lying in bed receiving a feeding of Glucerna 1.5 Cal at 55 cc/hr per Percutaneous Endoscopy Gastrostomy (PEG) tube. During an interview at the 100/200 hall nurse's station on 1/25/11 at 1:30 PM, Nurse #7 was</td>
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<td>F 280</td>
<td></td>
<td>Resident # 17 - The care plan was revised 01-26-11 to address measures to be used for emergency bleeding. MDS Coordinators were in-serviced 01-28-11 regarding the requirement for care plan interventions for these diagnoses and conditions. Other residents with these diagnoses and conditions will be reviewed to assure compliance with appropriate interventions. The QA Team, consisting of the Medical Director, Administrator, Director of Nursing, MDS Coordinator, Staffing Coordinator, Medical Records, Bookkeeper, Food Service Supervisor, Social Worker, Risk Management Nurse, Maintenance Supervisor, and Activities Coordinator, will monitor for compliance monthly for three months through random care plan audits to ensure compliance. If compliance is not met, the team, will re-inservce the MDS Coordinators and continue monitoring until substantial compliance is achieved. Different members of the QA Team will participate depending on the nature of the audit. Completion Date: 02-15-11</td>
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F 280  Continued From page 2
asked if Resident #10 received pleasure foods. Nurse #7 stated, "He [Resident #7] doesn't get a pleasure tray any more. He failed the swallow study that was done."

3. Medical record review for Resident #12 documented an admission date of 12/5/08 and a readmission date of 1/22/11 with diagnoses of Dementia, Organic Psychotic Condition, Diabetes Mellitus Type 2, Hypothyroidism and Congestive Heart Failure. Review of the annual Minimum Data Set (MDS) with an assessment reference date of 11/23/10 documented, "...Section G... Activities of Daily Living (ADL) Assistance... Dressing... 2 [Limited assistance] 2 One Person Physical Assist... Section H Bladder and Bowel... Urinary incontinence...Occasionally incontinent..." Review of the comprehensive care plan reviewed 11/24/10 included no interventions for urinary incontinence and assistance with dressing.

During an interview at the 100/200 nurse's station on 1/25/11 at 8:45 AM, Nurse #10 reviewed Resident #12's comprehensive care plan and confirmed the care plan did not include interventions for urinary incontinence or assistance with dressing.

4. Medical record review for Resident #16 documented an admission date of 1/7/11 with diagnoses of Anemia, Renal Dysfunction and Malnutrition. Review of the care plan dated 1/20/11 documented, "...Monitor access area for redness/pain and report..."

During an interview in the activity room on 1/25/11 at 8:15 AM, Nurse #3 confirmed that the care plan did not address measures to be used for emergency bleeding from the access area.
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<th>F 280</th>
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<tr>
<td>5. Medical record review for Resident #17 documented an admission date of 12/8/09 with diagnoses of Sinus Allergies, Myocardial Infarction, End Stage Renal Disease on Hemodialysis, Diabetes and Hypothyroidism. Review of the care plan dated 12/16/10 documented, &quot;...Assess AV [Arterial Venous] site...[left upper extremity] for abnormal bleeding.&quot; The care plan did not address measures to be used for emergency bleeding.</td>
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<tr>
<th>F 282</th>
<th>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS PER CARE PLAN</th>
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<tr>
<td>Requirement:</td>
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<td>The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care.</td>
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<td>Correction:</td>
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<tr>
<td>Resident #5 and 6 – Documentation of these residents' bowel movements were audited to determine if laxatives and/or enemas should be administered to induce bowel movements. Other residents' nurse aide care sheet were audited to determine if they were in need of interventions to induce bowel movements. Nursing staff was re-instructed regarding plan of care interventions regarding bowel movements.</td>
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<tr>
<th>F 282</th>
<th>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS PER CARE PLAN</th>
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<tbody>
<tr>
<td>Services were provided to all residents as outlined in the care plan.</td>
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<tr>
<th>F 282</th>
<th>SS=D</th>
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<td>SS=D</td>
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The findings included:

1. Medical record review for Resident #5 documented an admission date of 5/2/09 with diagnoses of Urinary Tract Infection, Urinary Retention, Alzheimer's Disease, Depression, Atrial Fibrillation, Osteopenia and Hypertension. Review of the plan of care dated 12/30/10 documented, "...Will have a bowel movement at least every three days... Monitor bowel movements... and give laxatives as ordered and needed..." Review of Resident #5's nurse aide
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<td>F 282</td>
<td>Care sheet dated January 2011 had documented that Resident #5 had a bowel movement from 1/13/11 through 1/16/11 until an enema was given on 1/17/11. 2. Medical record review for Resident #6 documented an admission date of 7/7/10 with diagnoses of Anemia, Renal Insufficiency, Hypertension, Left Femoral Fracture, Right Humerus Fracture and Arthritis. Review of the plan of care dated 10/12/10 documented, &quot;...Risk for constipation due to decreased mobility, meds [medications] &quot;Will have a bowel movement at least every 3 days... Monitor bowel movements... and give laxatives as ordered and needed...&quot; Review of Resident #6's nurse aide care sheet dated January 2011 had no documentation that Resident #6 had a bowel movement from 1/14/11-1/17/11 until an enema was given on 1/18/11. During an interview at the 100 hall nurses station on 1/26/11 at 10:18 AM, Nurse #3 was asked when do they do something when a resident did not have a bowel movement and what did they do. Nurse #8 stated, &quot;after 72 hours the nurse will give the resident something to help them have a bowel movement. If no bowel movement, follow protocol and call doctor.&quot;</td>
<td>F 309</td>
<td>F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING SS=D</td>
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STATEMENT OF DEFICIENCIES
A PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
DYERSBURG MANOR NURSING HOME

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

ID PREFIX TAG
F 309

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observations and interviews, it was determined the facility failed to follow the physician's medication orders for 1 of 24 (Resident #23) sampled residents and 2 of 3 Random Residents (RR) #2 and 3).

The findings included:

1. Medical record review for Resident #23 documented an admission date of 12/2/10 with diagnoses of Congestive Heart Failure, Diabetes Mellitus Type 2, Hypertension, History of Deep Vein Thrombosis and Depression. Review of a physician's order dated 12/2/10 documented, "...Travatan eye gtt's [drops] 1 gtt both eyes daily..."

During an interview in the activity office on 1/26/11 at 9:10 AM, Nurse #10 was asked if there was an order for the amount of Travatan eye gtt's for Resident #23. Nurse #10 reviewed Resident #23's orders and stated, "...Looks like there is no order for the amount. They [nurses] probably looked back to the hospital orders for the order. They [nurses] shouldn't go by that [hospital order]. They [nurses] should have clarified the order with the doctor."

2. Medical record review for RR #2 documented an admission date of 6/28/04 with diagnoses of Depression, Neuropathy, Hypertension, Chronic Obstructive Pulmonary Disease and Congestive Heart Failure. Review of a physician's order dated 12/1/10 through 12/31/10 documented,

F 309 Correction:
Resident #23 - The physician's order for Travatan eye gtt's was clarified with the physician on 01-26-11 regarding the amount of eye gtt's.
RR #2 - This resident was assessed by the charge nurse for any adverse effects regarding the time the TTO patch was in place and the attending physician was notified on 01-24-11.
RR #3 - The physician's order for Artificial Tears optical drops was clarified with the attending physician regarding which eye(s) were to receive the drops 01-24-11. This resident was assessed by the charge nurse for any adverse effects regarding receiving Artificial Tears in both eyes.
Nursing staff was in-serviced regarding the required elements of a physician's order, and the need to follow physician's orders as written.
The QA Team, consisting of the Medical Director, Administrator, Director of Nursing, MDS Coordinator, Staffing Coordinator, Medical Records, Bookkeeper, Food Service Supervisor, Social Worker, Risk Management Nurse, Maintenance Supervisor, and Activities Coordinator, will monitor for compliance monthly for three months through random physician order and medication administration audits to ensure compliance. If compliance is not met, the team will re-inservice and continue monitoring until substantial compliance is achieved. Different members of the QA Team will participate depending on the nature of the audit.

Completion Date: 01-31-11
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<th>(X3) COMPLETION DATE</th>
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<td>F 309</td>
<td>Continued From page 6</td>
<td>&quot;...NITROGLYCERIN PATCH 0.2MG [milligram] / [per] HR [hour] APPLY ONE PATCH EVERY MORNING REMOVE AT 8-PM DOCUMENT SITE...&quot;</td>
<td>F 309</td>
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Observations in RR #2's room on 1/24/11 at 7:15 AM, Nurse #1 started to apply the Nitroglycerin (NTG) 0.2 mg/hr transdermal patch on the left chest wall and found a NTG transdermal patch on that area. Nurse #1 removed the patch and applied the new patch to the right chest wall.

During an interview at the 100 hall nurses' station on 1/24/11 at 9:05 AM, the surveyor asked the Director of Nursing (DON) to review the physician's orders 12/1/10 - 12/31/10 related to the NTG patch. The surveyor asked the DON what the order meant. The DON stated, "...[NTG] patch to be removed 8 PM and to go without patch from 8 PM to 8 AM..."

During an interview at the 100 hall nurses' station on 1/24/11 at 12:20 PM, Nurse #1 stated, "...I did remove the nitro patch [at 7:15 this AM] from the left chest and then placed new patch on the right chest..."

3. Medical record review for RR #3 documented an admission date of 12/18/10 with diagnoses Altered Mental Status secondary to Dilantin Toxicity and Urinary Tract Infection, Generalized Weakness and Decreased Appetite. Review of a physician's order dated 12/21/10 documented, "...Artificial tears 1 [one] gtt [drop] optical 4x [four times] daily..."

Observations in RR #3's room on 1/24/11 at 5:57 AM, revealed Nurse #3 administered one drop into each of RR #3's eyes.
Continued From page 7

During an interview at the 100 hall nurses' station on 1/24/11 at 8:20 AM, the surveyor asked the Assistant Director of Nurses (ADON) to review the order dated 12/21/10 related to Artificial Tears optical drops. The ADON stated, "...one drop qid [four times a day], it does not say which eye... the nurse copied the orders off the hospital medication reconciliation sheet..."

483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

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...
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

Provider/Supplier/Clinic Identification Number: 445446

**[X]** PROVIDER/ SUPPLIER/CLINIC IDENTIFICATION NUMBER:

A. BUILDING ____________________
B. WING ____________________

**[X]** MULTIPLE CONSTRUCTION

**DATE SURVEY COMPLETED**

NAME OF PROVIDER OR SUPPLIER:

DYERSBURG MANOR NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE:

1900 Pahr Avenue
DYERSBURG, TN 38024

**[X]** COMPLETION DATE

01/26/2011

F 431

**[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-REFERENCES TO THE APPROPRIATE DEFICIENCY)

**[X]** COMPLETION DATE

**F 431**

**Correction:**

Nurse #1 retrieved the insulin filled syringe; the opened multi-dose vial of Tuberculin Mantoux was removed from the refrigerator and disposed of properly. The nursing staff, was in-serviced regarding (a) the requirement that medication must never be left unattended or out of view; and (b) that whenever the seal of a multi-dose vial is broken, it must be initialed and dated by the nurse with an opened date.

The QA Team, consisting of the Medical Director, Administrator, Director of Nursing, MDS Coordinator, Staffing Coordinator, Medical Records, Bookkeeper, Food Service Supervisor, Social Worker, Risk Management Nurse, Maintenance Supervisor, and Activities Coordinator, will monitor for compliance monthly for three months through random medication administration and storage audits to ensure compliance. If compliance is not met, the team will re-inservice nursing staff and continue monitoring until substantial compliance is achieved. Different members of the QA team will participate depending on the nature of the audit.

Completion Date: 01-31-11

**Continued From page 8**

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, observations and interviews, it was determined 1 of 10 nurses (Nurse #1) left an insulin filled syringe unattended and out of her view and the facility failed to ensure an opened multi-dose vial was labeled when stored in 1 of 7 (100 hall medication room) medication storage areas.

The findings included:

1. Observations in room 107 B (100 hall) on 1/25/11 at 8:00 AM, Nurse #1 left an insulin filled syringe on Random Resident (RR) #1's overbed table. Nurse #1 left the room to get a lancet and left the medication filled insulin syringe unattended and out of her view.

During an interview in the 100 hallway on 1/25/11 at 9:25 AM, Nurse #1 stated, "I left the insulin syringe on the table... I should have taken it with me..."

2. Review of the facility's "Medication Storage" policy documented, "...When ever the seal of a multi-dose vial of medication is broken it must be initialed and dated by the nurse with an opened date; also suggested is to label the vial with the expiration date..."

Observations of the 100 hall medication room on
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<td>F 431</td>
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<td>Continued From page 9 1/26/11 at 8:10 AM, revealed an opened multi-dose vial of Tuberculin Mantoux in the refrigerator not labeled. During an interview in the 100 hall medication room on 1/26/11 at 8:15 AM, the Assistant Director of Nurses stated, &quot;...there is no date on this vial... I will place it in the sharps box.&quot;</td>
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<td>F 441</td>
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<td>SS-D</td>
<td>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 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted</td>
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<td>F 441</td>
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<td>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS SS-D Requirement: 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. (a) Infection Control Program The facility will 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 will isolate the resident.</td>
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**NAME OF PROVIDER OR SUPPLIER**
DYERSBURG MANOR NURSING HOME

**STREET ADDRESS, CITY, STATE, ZIP CODE**
1900 PARR AVENUE
DYERSBURG, TN 38024

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLA Identification Number:**
445446

**(X2) Multiple Construction**
- A. Building
- B. Wing

**(X3) Date Survey Completed:**
01/26/2011

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**F 441**
Continued From page 10

(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, observations and interviews, it was determined the facility failed to ensure practices to prevent the potential spread of infection was maintained when 1 of 10 (Nurse #5) nurses failed to practice handwashing during medication administration pass; 2 of 5 Certified Nursing Assistants (CNA #1 and #2) failed to wash their hands during dining observations; pill splitters were not cleaned on 3 of 5 medication carts (1st 400 hall medication cart, 2nd 400 hall medication cart and 200 hall medication cart) and the scoop was inside the ice chest on 2 of 3 (1/25/11 and 1/26/11) days.

The findings included:

1. Review of the facility's "HANDWASHING" policy documented, "...Hand Hygiene... Between direct contact with patients... After removing gloves... Before serving food..."

a. Observations in room 306 on 1/25/11 at 8:45 AM, Nurse #6 donned gloves, administered medications through the resident's Percutaneous Endoscopy Gastrostomy tube, and removed the gloves from her hands. Nurse #6 did not wash her hands after removing the gloves.

(2) The facility will 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 will require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practices.

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

Correction:
Nurse # 6, CNA # 2, CNA # 1, and the nursing and CNA staff, were in-serviced regarding proper hand washing practice and the proper placement and storage of ice scoops; the nursing staff was in-serviced regarding the proper cleaning of pill-splitters after each use.
The QA Team, consisting of the Medical Director, Administrator, Director of Nursing, MDS Coordinator, Staffing Coordinator, Medical Records, Bookkeeper, Food Service Supervisor, Social Worker, Risk Management Nurse, Maintenance Supervisor, and Activities Coordinator, will monitor for compliance monthly for three months through random audits of medication administration passes, meal services and ice chests, to ensure compliance. If compliance is not met, the team will re-inservice CNA staff and nursing staff and continue monitoring until substantial compliance is achieved.
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<th>(X4) ID PREFIX</th>
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<td>F 441</td>
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<td>b.</td>
<td>Observations in room 413 on 1/24/11 at 8:20 AM, Certified Nursing Assistant (CNA) #2 placed the meal tray on the over bed table in room 413, raised the head of the bed, repositioned the resident, opened the resident's straw and handled the resident's utensils without washing her hands.</td>
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<td>c.</td>
<td>Observations in room 103 on 1/25/11 at 11:35 AM, CNA #1 obtained the meal tray from the meal cart. CNA #1 delivered the meal tray, cranked the head of bed up, repositioned the resident, opened the window curtain, prepared the tray, opened and touched the straw with her bare hand, and used the straw to mix the sweetener in the tea. CNA #1 did not wash her hands before obtaining the tray from the meal cart, after touching the resident or before preparing the meal tray.</td>
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|               |     | Observations in room 110 on 1/25/11 at 11:50 AM, CNA #1 delivered the meal tray, cranked the head of bed up, repositioned the resident, removed the lid from three cups and began to feed the resident. CNA #1 did not wash her hands after touching the resident, prior to meal tray preparation or before she fed the resident. During an interview at the 100 hall nurses' station on 1/26/11 at 10:50 AM, the Assistant Director of Nurses (ADON) was asked what is the expectation of hand hygiene during meal tray delivery and preparation. The ADON stated, "...expect if touch environment or resident should wash hands prior to touching meal tray..."
|               |     | 2. Observations at the 300/400 Nurse's station on 1/25/11 at 11:35 AM, revealed a build up of yellow and white particles inside the pill splitter on the 1st 400 hall medication cart and the pill splitter for the 2nd 400 medication cart contained |           |     |                                                                                                                |                     |
|               |     |                                                                                                                                |           |     |                                                                                                                |                     |
|               |     |                                                                                                                                |           |     |                                                                                                                |                     |
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loose white particles on the inside.

During an interview at the 300/400 Nurse's station on 1/25/11 at 11:40 AM, Nurse #5 was asked if the pill splitter was clean. Nurse #5 looked at the pill splitter and stated, "It's not clean. It's really dirty and should have been cleaned with alcohol." Nurse #5 looked at the 2nd pill splitter and stated, "It's not clean either.

Observations in the 100 hall on 1/25/11 at 3:25 PM, revealed a buildup of orange particles on the blade of the pill splitter on the 200 hall medication cart.

During an interview in the 100 hall on 1/25/11 at 3:25 PM, Nurse #4 was asked if the pill splitter was clean. Nurse #4 looked at the pill splitter and stated, "...supposed to clean it after each pill so I do not know what that is [substance inside the pill splitter]."

3. Observations in the 300 hallway on 1/25/11 at 10:45 AM, revealed CNA #3 passing ice from room to room. CNA #3 entered the residents' rooms, returned to the ice cooler and used the scoop from inside the cooler to fill the pitchers with ice. CNA #3 placed the scoop back inside the cooler.

Observations in the 300 hallway on 1/25/11 at 10:47 AM, revealed CNA #5 entered the hallway from a resident's room carrying a water pitcher. CNA #5 used the scoop inside the cooler and filled the pitcher. CNA #5 placed the scoop back inside the cooler.

Observations in the dining room on 1/26/11 at 9:15 AM, revealed the ice cooler stored in the
**Summarized Text**: Continued From page 13

During an interview in the 300/400 hallway on 1/25/11 at 10:50 AM, CNA #3 was asked what was the container on the shelf under the cooler used for. CNA #3 stated, "It's [the container] to keep the ice scoop in when we are not using it."