**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID</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>TAG</th>
<th>PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<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>
<td>F 280</td>
<td>SS=D</td>
<td>This Plan Of Correction is being submitted as required by Federal regulations. The submission of this Plan Of Correction is not to be construed as an admission by the facility as to the accuracy of the citations nor finding of facts. Please accept this as our Plan of Correction.</td>
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</tbody>
</table>

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 and interview, it was determined the facility failed to revise the comprehensive care plan for interventions for weight loss for 1 of 15 (Resident #5) sampled residents.

The findings included:

Medical record review for Resident #5 documented an admission date of 4/17/09 with diagnoses of Rheumatoid Arthritis, Hypertension, Hypothyroidism, Sinusitis, Chronic Obstructive Pulmonary Disease, Pulmonary Fibrosis, and...

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LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

[Signature]

**Administrator**

[Signature] 6/1/2010

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 disclosed 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosed 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>
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<tr>
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<tr>
<td>F 280</td>
<td>Continued From page 1 Renal Insufficiency. Review of the care plan dated 1/28/10 and reviewed on 2/9/10 and 5/7/10 documented &quot;...Risk for alteration in nutrition: less than body requirements...&quot; Review of the Consultant Dietitian's recommendations dated 2/4/10 documented, &quot;Problem identified w/ [weight] loss... Recommendation... Offer yogurt betw [between] meals &amp; [and] revisit for meal pref [preference] update esp [especially] check to see of any certain foods she's having difficulty with b/c [because] of recent c/o [complaint] of heartburn. Offer additions @ [at] meals to her like soup, sand [sandwich] ice cream etc. [etcetera] until her appetite picks back up to normal... I put it as our intervention for her weight loss...&quot;</td>
<td>F 280</td>
<td>3. MDS Nurse will audit residents with weight loss Plans of Care weekly. monthly x 3 months then quarterly x 3 months then quarterly to assure weight loss interventions accurately reflected on Plan of Care.</td>
<td>06/03/2010</td>
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<tr>
<td>F 309</td>
<td>482.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain</td>
<td>F 309</td>
<td>4. a) Plans of Care for residents with weight loss will be reviewed monthly x 3 months, then quarterly per DON or Designee to assure weight loss interventions are accurately reflected on Nursing Plan of Care. b) Findings will be reported to QA Committee quarterly by the DON or Designee. The QA committee consist of the following: Nursing Home Administrator, Director of Nursing, Medical Director, Social Service Director, Activity Director, Dietary Manager, MDS Coordinator, Medical Records, Maintenance Supervisor, Business Office Manager and any others appointed by the Administrator.</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**[X4] PROVIDER/SUPPLIER/COLA IDENTIFICATION NUMBER:** 445355

**[X5] MULTIPLE CONSTRUCTION**
A. BUILDING ____________________
B. WING ________________________

**[X6] DATE SURVEY COMPLETED:** 06/03/2010

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**NAME OF PROVIDER OR SUPPLIER:** OAKWOOD COMMUNITY LIVING CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 1638 WOODLAWN

DYERSBURG, TN 38024

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**[X7] ID PREFIX TAG**

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<tr>
<td>F 309</td>
<td>Continued From page 2 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</td>
<td>F 309</td>
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**This REQUIREMENT Is not met as evidenced by:**

Based on medical record review, observation and interview, it was determined the facility failed to follow physician's plan of care / orders for protective heel boots for 1 of 10 (Resident #2) sampled residents.

The findings included:

- Medical record review for Resident #2 documented an admission date of 5/16/07 with diagnoses of Fracture of Pubis-Closed, Difficulty in walking, Acute Pancreatitis, Hepatitis, White Blood Cell (WBC) Disease, Renal Failure, Lack Of Coordination, Dizziness and Giddiness and Lymphedema. There was a documented history of pressure sores on her heels. Review of the physician's plan of care / order dated 6/8/10 documented, "PROTECTIVE HEEL BOOTS ON BOTH FEET AND FLOAT HEELS WHILE IN BED... OFF LOAD HEELS W/ [with] PILLOWS WHILE IN BED. MONITOR Q [every] SHIFT."

Observations in Resident #2's room on 6/1/10 at 12:50 PM; on 6/2/10 at 8:35 AM, 9:30 AM, 11:40 AM and 3:25 PM; and on 6/3/10 at 9:05 AM, revealed Resident #2 lying in bed. Resident #2's heels were not floating and she was not wearing protective heel boots as ordered on the dates and times as noted above.

1. Resident #2’s heel protectors were applied and heels were offloaded per Treatment Nurse on 6/3/10.

2. a.) Residents with orders for heel protectors and offloading of heels were assessed to assure heel protectors in place and heels off loaded per order and plan of care on 6/3/2010 per Treatment Nurse.
b.) Residents with orders for heel protectors and offloading of heels were placed per treatment nurse in heel protectors and heels offloaded per order and Plan of Care on 6/3/2010.

c.) Nursing staff were inserviced on 6/3/2010 and 6/11/2010 per DON, regarding placement of heel protectors and offloaded heels for those residents with orders for them as well as care planned for them.

3. a.) Nursing staff will be inserviced upon hire and annually per DON or Designee regarding following MD Orders and Plan of Care related to Heel protectors and offloading Heels.
b.) Treatment Nurse or charge Nurse to make daily rounds to assure heel protectors are in place as well as heels off loaded for resident with orders for this and per Plan of Care
**Statement of Deficiencies and Plan of Correction**

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<th>Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or local identifying information)</th>
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<th>Tag</th>
<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>(X3) Completion Date</th>
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<tr>
<td>F 309</td>
<td>Continued From page 3</td>
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<td>During an interview in Resident #2's room on 6/3/10 at 10:45 AM, Nurse #5 stated, &quot;They [heel protectors] are suppose to be on at all times... I got them [heel protectors] out of closet a little while ago...&quot;</td>
<td>F 309</td>
<td>a) DON or Designee will make weekly rounds to assure heel protectors are in place and heeled offloaded per order and Plan of Care.</td>
<td>11/11/10</td>
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<td>F 323</td>
<td>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</td>
<td></td>
<td>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</td>
<td>F 323</td>
<td>b) Findings will be reported to the QA Committee quarterly by the DON or Designee. The QA committee consist of the following: Nursing Home Administrator, Director of Nursing, Medical Director, Social Service Director, Activity Director, Dietary Manager, MDS Coordinator, Medical Records, Maintenance Supervisor, Business Office Manager and any others appointed by the Administrator.</td>
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This REQUIREMENT is not met as evidenced by:

Based on policy review, review of the facility investigations, medical record review and interview, it was determined the facility failed to put appropriate interventions in place to prevent falls for 4 of 7 (Residents #2, 4, 8 and 10) sampled residents with falls.

The findings included:

1. Review of the facility's "Falls" policy documented, "A Falls Risk Assessment is to be completed on admission and updated at least quarterly. If the score of the assessment is above 10, the resident will be considered at risk for falls and the fall potential should be addressed on the resident's care plan and the CNA's [certified nursing assistants] Information Sheet. If the resident has fallen, the resident will be considered at risk, regardless of the score. In the process of identifying factors that might contribute to falls,
Continued from page 4

1. Review the following areas... if a fall occurs... 1. Incident and Accident report is to be filled out at the time of the fall and reviewed in stand up/morning meeting and addressed on the 24 hour report. 2. Documentation is initiated at the time of the fall and continues, at a minimum, of every shift for 72 hours or until the condition stabilizes. 3. Fall investigation and Supervisor Report is to be completed. 4. Resident history of fall is an ongoing document (do not start one each month). This is to be completed with each fall and kept in a notebook. 5. Care Plan needs to be updated with each fall. 6. All these forms need to be completed at the end of the three days of documentation and kept together in the Liability incident Analysis Book a) [Incident] b) [Accident] report c) Fall investigation/supervisor report d) Any statements e) If resident is sent to the hospital, copies of hospital reports should be copied and kept with the above information...


Review of the fall risk assessments documented fall assessments were done on 11/18/09 with a...
Continued From page 5

score of 12 and on 3/10/10 with a score of 16, both assessing Resident #2 as high risk. The fall risk assessment was not done quarterly according to the facility's policy.

Review of Resident #2's care plan dated 3/10/10 documented, "Potential for cognitive loss at [related to] Alzheimer's Dementia. Risk for falls not evaluated and veri..." The care plan documented that the resident had a fall on 3/14/10 and 3/28/10 with no interventions put in place to prevent future falls.

Review of the nurses notes dated 3/14/10 at 11:45 PM documented, "Called to residents [2] room per CNA. Observed resident sitting in [on] floor by bedside table stating, 'I need to go to the bathroom and pee... Re-instructed patient she has Foley cath. Her to urinate in. Unsure of resident's comprehension of purpose of Foley cath. Diagnosed dementia. Re-oriented patient to use call light for assistance..." The nurses notes dated 3/28/10 at 7:45 PM documented, "Called to residents room per CNA. Observed resident sitting in [on] floor by bed, stating 'I don't know what to do, I just needed to go to the bathroom.' ... Assisted resident back to bed. Re-instructed resident to use call light when needing assistance. Unsure of residents comprehension of use of call light D/T dementia..." Instructions given to the resident was inappropriate in relation to Resident #2's cognitive status.

Medical record review for Resident #4 documented an admission date of 12/17/09 with diagnoses of Cerebrovascular Accident, Hypertension, Osteoarthritis, Depression, Anxiety, Peripheral Neuropathy, Hypothyroidism and Ankle Fracture. Review of the MDS dated 3/10/10.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(x1) PROVIDER/SUPPLIER/CWA
IDENTIFICATION NUMBER:

448335

(x2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(x3) DATE SURVEY COMPLETED
06/03/2010

NAME OF PROVIDER OR SUPPLIER
OAKWOOD COMMUNITY LIVING CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1835 WOODLAWN
DYERSBURG, TN 38024

(x4) ID
PREFIX
TAG:

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

F 323
Continued From page 6

documented "...Fall in past 30 days... Fall in past
31-150 days..." Review of Resident #4's care
plan dated 12/28/09 documented "Risk for falls n/t
unsteadiness..." The care plan documented that
Resident #4 had a fall on 12/27/09, 2/11/10,
2/15/10 and 4/28/10. There were no interventions
put in place after each fall to prevent future falls.

There was no fall risk assessment found on
Resident #4's medical record.

During an interview in the break room on 6/2/10
at 6:10 PM, the Director of Nursing (DON) was
asked what the process was for updating care
plans after a resident falls. The DON stated,
"...Once a fall occurs the nurse is responsible for
updating the care plan and the MDS nurse
reviews the next morning to be sure correct..."

The DON was asked if the fall that Resident #4
had on 5/26/10 had been care planned with
interventions put in place. The DON stated,"...No
it is not..."

During an interview in the break room on 6/31/10 at
10:15 AM, the DON was asked if there was a fall
risk assessment completed for Resident #4. The
DON stated, "...I am going to be honest with you,
this is the fall risk assessment as of right now. I
have looked everywhere and can't find it..." The
surveyor then asked the DON if the fall risk
assessment was on the medical record. The
DON stated, "No."

4. Medical record review for Resident #8
documented an admission date of 11/19/08 with
diagnoses of Chronic Obstructive Pulmonary
Disease, Upper Respiratory Infection, Diabetes
Mellitus, Gastroesophageal Reflux Disease,
Hypertension, Coronary Artery Disease,
**F 323** Continued From page 7

Cerebrovascular Disease and Atrial Fibrillation.

Review of the MDS dated 5/14/10 documented 
"...84 COGNITIVE SKILLS FOR DAILY DECISION MAKING... 0. independent-decisions consistent/reasonable. 1. MODIFIED INDEPENDENCE- some difficulty in new situations only. 2. MODERATE IMPAIRED-decisions, cues/supervision required. 3. SEVERELY IMPAIRED-never/rarely made decisions... ACCIDENTS... Fall in past 31-40 days..." Review of Resident #8's care plan dated 2/12/10 documented, "Risk for falls /1 unsteadiness..." The care plan documented that Resident #8 had a fall on 3/23/10. There were no interventions documented on the care plan after each fall. Nurses notes documented Resident #8 had falls on 3/23/10 and 4/23/10.

Review of the facility's investigations for the 3/23/10 and 4/23/10 falls documented 
"...reinstruct the resident unsure of resident's comprehension..."

During an interview in the break room on 6/3/10 at 12:55 PM, the DON was asked if the intervention found on the investigation report was appropriate for Resident #8. The DON stated, 
"...Totally ridiculous..." The DON was asked how do you reorient someone with Dementia and the DON stated, "...you can't..." The DON was asked about interventions on the care plan for Resident #8. The DON stated, "...I don't have anything I can defend right now we are struggling..."

5. Medical record review for Resident #10 documented an admission date of 2/12/10 with diagnoses of Malaise and Fatigue, Lack of Coordination, Difficulty in Walking, Fracture Femur, Hypertension, Vascular Dementia and
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<td>F 323</td>
<td>Continued From page 8</td>
<td>Abnormality Of Gait. Review of the the full MDS dated 2/23/10 documented, &quot;Section G1. 3. EXTENSIVE ASSISTANCE... (B)... 3. Two + [plus] persons physical assist 3. EXTENSIVE ASSISTANCE... (B) 2. One person physical assist...&quot; Resident #10's care plan dated 2/12/10 documented, &quot;Risk for falls n/u unsteadiness and hx [history] of falls prior to admission.&quot; There were no interventions on the care plan for the fall on 2/23/10. Review of the fall risk assessment documented fall assessments done on 2/12/10 with a score of 4 and on 6/3/10 with a score of 14. The score of 14 assessed the resident as being at a high risk for falls. The fall risk assessment was not done quarterly according to the facility's policy.</td>
<td>F 323</td>
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<td>F 441</td>
<td>SS=E</td>
<td>During an interview in the break room on 6/6/10 at 1:00 PM, the DON confirmed that she was ultimately responsible in making sure that falls and interventions are put in place. 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.</td>
<td>F 441</td>
<td>SS=E</td>
<td>1. a) Nurse #1 was inserviced on 6/2/2010 regarding infection control policy and proper cleaning of Stethoscope before and after use per DON. b) Nurse #2 was inserviced on 6/3/2010 regarding infection control policy and proper cleaning of eye drop bottle prior to placing in med cart per DON. c) Nurse #3 was inserviced on 6/3/2010 per DON regarding infection control policy to include removal of gloves, hand washing policy and proper cleaning of stethoscope as well as oxygen.</td>
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Continued From page 9 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 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, observations and an interview, it was determined the 4 of 5 nurses (Nurses #1, 2, 3 and 4) failed to maintain infection control practices to prevent the possibility of cross-contamination by not cleaning resident equipment; improper handling of an eye drop container and intravenous (IV) medication bag; and improper handwashing.

The findings included:

1. Review of the facility's handwashing policy documented "Handwashing... 1. All personnel shall wash their hands to prevent the spread of saturation machine before and after use.

d.) Nurse #4 was in serviced on 6/2/2010 per DON regarding infection control policy to include changing of gloves, hand washing policy and cleaning of equipment following potential contamination;

2. a.) Resident infections were reviewed per DON on 6/4/2010 to assure no potential relation to infection control process, hand washing, or cleaning of shared equipment.

b. New cleaning equipment policy reviewed per QA team on 6/9/2010. Staff were in serviced on 6/11/2010 per DON regarding infection control policy, hand washing policy and cleaning of equipment policy.

c.) New cleaning of equipment policy was implemented on 6/11/2010.

3. a.) Staff will be inserviced upon hire and annually regarding infection control policy, hand washing policy and cleaning of equipment policy per DON or Designee.

b.) Resident infections will be monitored monthly per DON or Designee to assure Compliance with infection control Policy, hand washing policy and Cleaning of equipment policy.
**NAME OF PROVIDER OR SUPPLIER:**

**OAKWOOD COMMUNITY LIVING CENTER**

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

1630 WOODLAWN

DYERSBURG, TN 38024

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<td><strong>F 441</strong></td>
<td>Continued From page 10 infection and disease to other residents, personnel, and visitors. Appropriate... handwashing must be performed under the following conditions... b. Whenever hands are obviously soiled... 1. Before and after manipulation of IV sites or administration tubing... r. Upon completion of duty...2. Observations in Random Resident (RR) #1's room on 6/1/10 at 2:37 PM, revealed Nurse #1 placed the stethoscope on RR #1's abdomen to check for Percutaneous Endoscopic Gastrostomy (PEG) tube placement. Nurse #1 placed the stethoscope around her neck, and did not clean the stethoscope after use. 3. Observations in RR #2's room on 6/2/10 at 9:12 AM, revealed Nurse #2 placed the eye drop container in her uniform pocket, returned the eye drop container to the medication cart after administration of the eye drops, and did not clean the eye drop container prior to placing it in the medication cart. 4. Observations in RR #1's room on 6/2/10 at 11:30 AM, revealed Nurse #3 placed the oxygen saturation machine on RR #1's finger, and listened to RR #1's lungs with a stethoscope. Nurse #3 then placed the stethoscope and the oxygen saturation machine in a bin on the side of the medication cart. Nurse #3 did not clean the oxygen saturation machine or the stethoscope after use. Observations in RR #1's room on 6/2/10 at 11:33 AM, revealed Nurse #3 adjusted a fan with gloved hands during nebulizer medication administration through a tracheostomy, disconnected the nebulizer from the tracheostomy after completion,**</td>
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<td><strong>6/1/10</strong></td>
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4. a.) DON or Designee will make random observations monthly of staff hand washing, cleaning of equipment and infection control compliance.

b.) Findings will be reported to QA Committee quarterly by the DON or Designee. The QA committee consists of the following: Nursing Home Administrator, Director of Nursing, Medical Director, Social Service Director, Activity Director, Dietary Manager, MDS Coordinator, Medical Records, Maintenance Supervisor, Business Office Manager and any others appointed by the Administrator.

**COMMENTS:**

**COMPLAINTS:**

**REMARKS:**

[Handwritten note: **6/1/10**]
Continued From page 11

and cleansed the nebulizer medication reservoir without changing gloves or washing hands after adjusting the fan.

5. Observations in RR #4's room on 6/2/10 at 11:55 AM, revealed Nurse #3 removed gloves after checking RR #4's blood sugar, prepared an insulin injection to be administered to RR #4, donned gloves, and administered the insulin injection. Nurse #3 did not wash her hands after removing gloves and prior to administering the insulin injection.

6. Observations of IV medication administration in RR #5's room on 8/2/10 at 3:45 PM, revealed: Nurse #4 dropped the IV medication bag on the floor, picked up the IV medication bag with gloved hands, cleansed the connection site of the IV medication bag with alcohol, but did not clean the IV medication bag. Nurse #4 connected the IV tubing to the bag, and continued with the IV medication administration without changing gloves or washing hands. Nurse #4 did not wash her hands after completion of the IV medication administration.

7. During an interview in the break room on 8/3/10 at 6:20 AM, the Director of Nursing stated, "We do not have policy on cleaning of equipment... working on one [policy for cleaning equipment]."