## Statement of Deficiencies and Plan of Correction

**Statement of Deficiencies and Plan of Correction**

<table>
<thead>
<tr>
<th>Provider/Supplier/CLA Identification Number:</th>
<th>Multiple Construction</th>
<th>Date Survey Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>445440</td>
<td>A. Building</td>
<td>02/09/2011</td>
</tr>
<tr>
<td></td>
<td>B. Wing</td>
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</tr>
</tbody>
</table>

**Name of Provider or Supplier:**

GALLAWAY HEALTHCARE CENTER

**Street Address, City, State, ZIP Code:**

435 OLD BROWNSVILLE RD
GALLAWAY, TN 38036

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>Deficiency No.</th>
<th>Prefix</th>
<th>Tag</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 221</td>
<td>SS=d</td>
<td>483.13(a)</td>
<td>RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</td>
</tr>
</tbody>
</table>

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review, observations and interviews, it was determined the facility failed to pre-assess, assess or attempt to reduce restraints for 2 of 4 (Residents #7 and 13) sampled residents with restraints.

The findings included:

1. Review of the facility's "Use of Restraints" policy documented, "...8. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints... 16. Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction."

2. Medical record review for Resident #7 documented an admission date of 9/3/09 with diagnoses of Esophagitis Reflux, Hypertension, End Stage Dementia and Alzheimer's with Dementia. Review of a physician's order dated 12/28/10 documented, "...Lap buddy while up in wheelchair due to decrease cognition and safety awareness. Check every 30 minutes and release every two hours for ADL [Activities of Daily Living] care and repositions." The facility was unable to provide documentation that a pre-restraining assessment had been completed or that attempts acceptable per 21/21/11 were made.

### Provider's Plan of Correction

<table>
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<tbody>
<tr>
<td>F 221</td>
<td></td>
<td></td>
<td>This Plan of Correction constitutes the Facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not a admission that a deficiency exist or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the state and federal law.</td>
</tr>
</tbody>
</table>

F 221

1. Resident will have the right to be free from any physical restraint imposed for purposes of discipline, or convenience, and not required to treat the resident's medical symptoms.

2. Resident #7-Resident has been reassessed by the IDT to determine the need for the restraint and restraint reduction.

3. Current residents with an order for a restraint will be reviewed regularly (at least quarterly) to determine the need for restraints and whether they are candidates for a restraint reduction.

### Laboratory Director's or Provider/Supplier Representative's Signature

[Signature]

### Title

ADMINISTRATOR

### Date

02/25/11

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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 patient. (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.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CILA IDENTIFICATION NUMBER:**

445440

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING
B. WING

**(X3) DATE SURVEY COMPLETED:**

02/09/2011

---

**NAME OF PROVIDER OR SUPPLIER:**

GALLAWAY HEALTHCARE CENTER

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

435 OLD BROWNSVILLE RD
GALLAWAY, TN 38036

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### Summary Statement of Deficiencies

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<tr>
<td>F 221</td>
<td>Continued From page 1</td>
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- Observations in the meadow's living room on 2/7/11 at 9:30 AM, 12:40 PM and on 2/8/11 at 7:45 AM, revealed Resident #7 sealed in a high back wheelchair with a lap buddy in place.

- During an interview in the conference room on 2/8/10 at 8:20 AM, the Director of Nursing stated, "No quarterly physical restraint assessment, didn't put that part on the assessment."

- 3. Medical record review for Resident #13 documented an admission date of 9/19/08 and a readmission date of 11/19/08 with diagnoses of Affective Psychosis, Convulsions, Dementia and Anxiety. Review of the care plans dated 12/3/10 documented "...11/25/10- Fall... Approaches... 11/25/10 Lap buddy when 00B [out of bed] to w/c [wheelchair] 20 [secondary to] hx [history] falls, unable to transfer self due to..."

- Observations in Resident #13's room on 2/8/11 at 4:00 PM and 6:00 PM, revealed Resident #13 seated in a w/c with a lap buddy in place.

- During an interview at the 100 hall Nurses Station on 2/9/11 at 10:00 AM, Nurse #6 was asked about restraint assessments for Resident #13. Nurse #6 stated, "I can't find one of those [restraint assessments] either."

### Providers Plan of Correction

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<tr>
<td>F 221</td>
<td>4. Prior to placing a restraint, resident will have a pre-restraining assessment to determine the need for a restraint and be reviewed regularly (at least quarterly) to determine if they are a candidate for restraint reduction.</td>
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Corporate Director of Clinical Services provided In-service to DON/Nursing Management team on use of restraints.

In-service will be provided by DON/Staff Development Coordinator to all Licensed Nursing staff.

Newly hired Licensed Nurses will receive above in-service during orientation.

DON will review residents with restraints weekly x 4 weeks and then monthly ongoing.

### Right to Participate Planning Care

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...

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**Event ID:** UM0011

**Facility ID:** TN2403

**If continuation sheet Page:** 2 of 24
Continued From page 2
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 observation, it was determined the facility failed to revise the care plan to reflect the resident's current status to avoid aspirin or treatment for pneumonia for 2 of 23 (Residents #1 and 5) sampled residents.

The findings included:

1. Medical Record review for Resident #1 documented an admission date of 5/1/08 with diagnoses of Cerebral Vascular Accident, Stroke, Ischemic Heart Disease and Congestive Heart Failure. Review of the care plan dated 12/29/10 documented, "...AT RISK FOR ABNORMAL BLEED R/T [related to] antiplatelet antiplatelet] THERAPY [Plavix]... Approaches... AVOID ASA [aspirin] OR ASA RELATED PRODUCTS per physician orders..." Review of the physicians orders dated 2/2/11 documented "...ASPIR
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

[X1] PROVIDERS/Suppliers/CA
IDENTIFICATION NUMBER

445440

[X2] MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

[X3] DATE SURVEY COMPLETED

02/09/2011

NAME OF PROVIDER OR SUPPLIER

GALLAWAY HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

435 OLD BROWNSVILLE RD
GALLAWAY, TN 38036

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
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<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tbody>
<tr>
<td>F 280</td>
<td>Continued From page 3 [Aspirin]-LOW 81 MG [milligrams] TABLET -IE: [for example] BAYER ASPIRIN EC [enteric coated] 1 TAB BY MOUTH EVERY DAY...</td>
<td>F 280</td>
<td>DON/designee will do a random audit of 10% of clinical records monthly x 3 months for compliance.</td>
<td>03/11/11</td>
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<td></td>
<td>During an interview at 100 half nurses station on 2/8/11 at 2:00 PM, Nurse #1 was asked about Resident #1's care plan intervention for at risk for abnormal bleeding and to avoid aspirin products. Nurse #1 stated, &quot;Well I don't know, she is on Plavix and she is on aspirin also...&quot;</td>
<td></td>
<td>5. Results of audits will be presented to Facility Quality Assurance Committee monthly x 3 months to assess effectiveness of system.</td>
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<td>2. Medical record review for Resident #6 documented an admission date of 2/8/10 with diagnoses of Hepatitis C, Esophageal Reflux, Hyperlipidemia, Status Post Cerebral Vascular Accident and Vascular Dementia. On 1/28/11 a chest x-ray and complete blood count was completed and medication ordered for a diagnosis of Pneumonia. Review of the most recent care plan revealed an update on 6/16/10. The care plan was no updated to address the resident's treatment plan for pneumonia. 493.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</td>
<td>F 282</td>
<td>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</td>
<td></td>
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<tr>
<td>F 282</td>
<td>SS=D</td>
<td>F 282</td>
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<td>2. Resident #4-has water pitcher with water and ice within reach and is being offered fluids during staff visits. Resident is also being prompted, cued and assisted during meals.</td>
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<td>3. All residents have water pitchers with ice and water within reach and are offered fluids during staff visits unless contraindicated.</td>
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<td>All residents are receiving the assistance needed during meal service.</td>
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This REQUIREMENT is not met as evidenced by:

Based on medical record review and observations, it was determined the facility failed to follow the plan of care for medication and hydration for 1 of 14 (Resident #4) sampled residents observed.
### F 282

**Continued From page 4**

The findings included:

Medical record review for Resident #4 documented an admission date of 5/26/10 with diagnoses of Failure to Thrive and Alzheimer's Dementia. Review of the care plan dated 12/2/10 documented, "Keep water pitcher [pitcher] w/in [within] reach and offer fluids. Set-up meal tray and prompt, cue and assist her to feed herself."

Observations during the initial tour of the facility on 2/7/11 beginning at 9:32 AM, revealed Resident #4 sitting up in bed. Her water pitcher was out of her reach on the overbed table, and had no ice in it.

Observations in Resident #4's room on 2/7/11 at 12:35 PM, Resident #4 was sitting in a wheelchair at her bedside eating her lunch. There was no staff in the room to prompt, cue and assist her to eat.

Observations in Resident #4's room on 2/8/11 at 11:15 AM, Resident #4 was sitting at her bedside feeding herself. There was no staff in the room to prompt, cue and assist her to eat.

Observations in Resident #4's room on 2/9/11 at 11:00 AM, Resident #4 was sitting in the wheelchair at the bedside. Her water pitcher was across the room on a table by the sink, out of her reach.

**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

<table>
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<tr>
<th>(4) ID</th>
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<td>F 282</td>
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<td>4. All Nursing staff in-serviced by DON/SDC on keeping water pitchers with ice and water within reach of resident and offering water during care and visits unless contraindicated. All Nursing staff in-serviced by DON/SDC on providing assistance needed to residents during meal service. Newly hired Nursing staff will receive the above inservices as part of orientation. Administrator/DON/Licensed Nurses/designee will monitor water pitchers with water and ice within residents reach 2x daily x 1 month; then daily x 1 month; then weekly x 1 month. Administrator/DON/Licensed Nurses/designee will monitor resident assistance during meal service 3x daily x 1 month; then daily x 1 month (random meals); then weekly x 1 month (random meals). 5. Results of monitoring will be presented to the Facility Quality Assurance committee monthly x 3 months to assess effectiveness of</td>
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F 309 Continued From page 5 accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to document interventions for lack of a bowel movement for 1 of 23 (Resident #8) sampled residents and failed to follow physician's orders for medications and fluid restrictions for 1 of 23 (Resident #11) sampled residents.

The findings included:
1. Medical record review for Resident #8 documented an admission date of 5/1/08 with diagnoses of Arthritis, Depression, Scoliosis, Malignant Hypertension, Dementia without Behavior Disturbances, Bone and Cartilage Disease and Osteoporosis. Review of the "ADL [Activities of Daily Living] FLOW RECORD" had no bowel movement documented from 12/9/10 through (-) 12/13/10 and no bowel movement from 12/16/10 - 12/21/10.

During an interview in the Director of Nursing (DON)’s office on 2/8/11 at 4:00 PM, the DON was asked what was done when there was no bowel movement and how long did they wait before an intervention was put in place. The DON stated, "It's standard of practice to implement an intervention. If no BM [bowel movement] in 3 days, give MOM [Milk of Magnesia] and if no BM in 24 hours, then next step is listen to bowel sounds in abdomen and check for stool in lower rectal vault. Then determine consistency [of stool] system.

F 309

1. Each Resident will receive and facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care.

2. Resident #8-Bowel movements are being documented and resident is receiving treatment per facility protocol and physician’s order.

Resident #11-no longer has condition requiring treatment. Resident #11-is on fluid restriction as ordered.

3. Bowel movements are being documented for all residents and residents are receiving treatment per facility protocol and physician’s order.

Residents on fluid restriction are receiving fluids as ordered.

4. Facility protocol for documentation of bowel movements and treatments as indicated has been revised by facility/physician.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**[X1] PROVIDER/SUPPLIER/CGLA IDENTIFICATION NUMBER:**

446440

**[X2] MULTIPLE CONSTRUCTION**

A. BUILDING ______________________
B. WING ______________________

**[X3] DATE SURVEY COMPLETED**

02/09/2011

**NAME OF PROVIDER OR SUPPLIER**

GALLAWAY HEALTHCARE CENTER

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

435 OLD BROWNSVILLE RD
GALLAWAY, TN 38038

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</table>
| F 309     |     | Continued From page 6 and if hard give enema, then notify doctor for further instructions.  
During an interview at the 100 hall nurses station on 2/9/11 at 8:35 AM, Nurse #4 stated,  
"...Supposed to have protocol for MCM after 72 hours [if no BM] and check to see if they had a BM each shift..."  
2. Medical record review for Resident #11 documented an admission date of 5/1/10 with diagnoses of End Stage Renal Disease, Hypertension, Seizures and Diabetes Mellitus. Review of a physician's order dated 11/4/10 documented, "Pramethrin 5% [percent] cream Apply topically to cover entire body and leave for 14 hrs [hours]. Repeat in 1 week." Review of the Medication Administration Record revealed the medication was administered on 11/5/10 but not on 11/12/10 as ordered.  
Review of the initial diet order and communication form completed when Resident #11 was admitted to the facility on 5/1/10 documented, "1200cc [cubic centimeters] fluid [fluid] restriction." Review of physician's order dated 5/1/10 documented, "NOVASOURCE RENAL - 1 CAN THREE TIMES DAILY (DO NOT COUNT IN FLUID RESTRICTION)." Review of the current physician's order dated 2/2/11 revealed no documentation of fluid restriction.  
During a telephone interview in the conference room on 2/9/11 at 8:15 AM, the dialysis clinic Registered Dietician stated Resident #11 is supposed to be on fluid restrictions and the order had been faxed to the facility in May, 2010.  
During an interview on the 100 hall on 2/9/11 at

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| F 309     |     | All Nursing staff in-serviced on documentation of bowel movements, follow-up and treatment per facility protocol/physician's orders.  
All Nursing staff in-serviced on fluid restriction, communication process to ensure that fluid restriction is maintained per physician's order.  
Newly hired Nursing staff will be receive the above in-service during orientation.  
DON/SDC/Designee will monitor bowel movement documentation and treatments provided 2xweek x 1 month, then weekly x 2 months.  
DON/SDC/designee will monitor residents on fluid restriction 2xweek x 1 month, then weekly x 2 months.  
Residents with new order for fluid restriction will be monitored in morning clinical meeting daily 5 x week ongoing.  
5. Results of audits will be presented to the facility Quality assurance committee monthly x 3 months to assess effectiveness of system. |
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA
IDENTIFICATION NUMBER:

445440

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED

02/09/2011

NAME OF PROVIDER OR SUPPLIER

GALLAWAY HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

435 OLD BROWNSVILLE RD
GALLAWAY, TN 38039

[X4] ID PREFIX TAG

F 309 Continued From page 7
3:00 PM, Nurse #1 stated, Resident #11 was not
on fluid restrictions.

F 312 483.25(a)(3) ADL CARE PROVIDED FOR
DEPENDENT RESIDENTS

A resident who is unable to carry out activities of
daily living receives the necessary services to
maintain good nutrition, grooming, and personal
and oral hygiene.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and observation,
it was determined the facility failed to provide
toileting care for Random Resident (RR #15)
during 1 of 2 dining observations.

The findings included:

Medical record review for RR #15 documented an
admission date of 11/17/10 with diagnoses of
Congestive Heart Failure, Hyperlipidemia,
Chronic Obstructive Pulmonary Disease,
Dehydration and Anxiety. Review of the Minimum
Data Set dated 11/17/10 documented under
Activities of Daily Living "...toilet use 3 [Extensive
assistance] and 2 [one person assist]."

Observations during the food tray pass in room
123 on 2/7/11 at 5:55 PM, RR #15 stated, "...I'm
wet from my knees up my back and I'm
freezing..." Certified Nursing Assistant (CNA) #2
stated, "Your CNA is in the dining room and I'm
passing out trays. When we finish passing out
trays we'll change you..." CNA #2 continued to
pass trays. CNA #2 passed two Licensed
Practical Nurses in the 100 hall without telling

[X5] ID PREFIX TAG

F 309

F 312

03/11/11

1. Residents who are unable to carry
out activities of daily living will receive
the necessary services to maintain
good nutrition, grooming and
personal and oral hygiene.

2. RR #15 is receiving incontinent
   care in a timely manner.

3. All incontinent residents are
   receiving incontinent care in a timely
   manner.

4. All CNA's/Nursing staff in-serviced
   by DON/SDC/designee on providing
   incontinent care timely and
   responding to residents request in a
timely manner.

   Newly hired CNA's/Nursing staff will
   be in-serviced on the above during
   orientation.

   Licensed Charge Nurses will monitor
   timeliness of providing incontinent
care daily during assigned shifts.

   DON/SDC/Designee will monitor
   timeliness of incontinent care2 x
   week x 1 month and weekly x 2
   months.
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<td>F 312</td>
<td>Continued from page 8 the resident about RR #15 being wet. CNA #2 went to a room and started feeding another resident without helping RR #15 or telling anyone else to help RR #15.</td>
<td>F 312</td>
<td>5. Results of monitoring will be presented to facility Quality Assurance Committee monthly x 3 months to assess effectiveness of system.</td>
<td>03/11/11</td>
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<tr>
<td>F 322</td>
<td>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</td>
<td>F 322</td>
<td>1. Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a nasogastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</td>
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</tr>
<tr>
<td>SS=D</td>
<td>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a nasogastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasopharyngeal ulcers and to restore, if possible, normal eating skills.</td>
<td></td>
<td>2. RR #4 medication is being dissolved in 30 ml H2O or per physician's order prior to administration per gastrostomy tube.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure staff diluted crushed medications prior to administering medications per Percutaneous Endoscopy Gastrostomy (PEG) tube for 1 of 2 random residents (RR #4) observed with a PEG tube.</td>
<td></td>
<td>3. All residents with gastrostomy tube medications are being dissolved in 30 ml H2O or per physician's order prior to administration per gastrostomy tube.</td>
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<td>The findings included: Review of the facility's &quot;Administering Medications through an Enteral Tube&quot; policy documented, &quot;...Dilute medications and flush the tube with room temperature or warm liquids. (Note: cold liquids may induce abdominal cramping)... Steps in Procedure...Dilute the crushed or split medication with 30 ml [milliliters] water (or prescribed amount).&quot;</td>
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<td>4. Licensed Nursing staff received in-service by DON/SDC/Clinical</td>
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<td>Observations in RR #4's room on 2/7/11 at 4:50</td>
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| F 322 | Continued From page 9 | F 322 | Pharmacy Liaison/Pharmacy Consultant on diluting medications per policy/physician’s order prior to administration per gastrostomy tube. Newly hired Licensed Nurses will receive the above in-service as part of orientation. 
DON/SDC/designee will observe Licensed Nursing staff medication administration per gastrostomy tube to ensure compliance 1 x shift (random to include all nurses) then random x 3 months. Newly hired Licensed Nurses will be monitored to ensure competency in this area. 
Pharmacy Consultant will monitor random Licensed Nurses during facility visits monthly. 
5. Results of monitoring will be presented to the facility Quality Assurance Committee monthly x 3 months to assess effectiveness system. |
<p>| F 332 | 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE | F 332 | | | |
| The facility must ensure that it is free of medication error rates of five percent or greater. |</p>
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</table>
| F 332 | Continued From page 10 orders, including any required time frame... The individual administering the medication must check the label THREE (3) times to verify the right medication, right dosage, right time and right method (route) of administration before giving the medication...

2. Review of the "MED-PASS COMMON INSULINS: Pharmacokinetics, compatibility, and properties" provided by the American Society of Consultant Pharmacists for typical dosing administration of insulin related to meals documented, "...Novolin R [Regular], ONSET [in hours unless noted] 0.5 - [to] 1... TYPICAL DOSSING / COMMENTS... give 30 minutes before meals..."


Observations in Resident #13's room on 2/7/11 at 4:15 PM, Nurse #2 administered 4 units of Novolin R to Resident #13. Resident #13 did not receive her meal until 5:20 PM. The administration of the Novolin R insulin more than 30 minutes before Resident #13 was served supper resulted in medication error #1.

During an interview on the 100 hall on 2/8/11 at 7:00 PM, Nurse #2 stated, "The time frame is 30 minutes before meals."
Continued From page 11

4. Medical record review for Random Resident (RR) #9 documented an admission date of 6/25/10 with diagnoses of Congestive Heart Failure, Diabetes Mellitus and Hypertension. Review of a physician's order dated 2/2111 documented, "...NOVOLIN R 100 U/MIL UNIT SSI: 200-300 = [amount of insulin to be administered] 4 UNITS, 301-400 = 8 UNITS..."

Observations in RR #9's room on 2/8/11 at 4:19 PM, Nurse #8 administered 8 units of Novolin R to RR #9. RR #9 did not receive his meal tray until 6:20 PM. The administration of the Novolin R more than 30 minutes before RR #13 received his supper resulted in medication error #2.

During an interview in the restorative dining room on 2/8/11 at 6:49 PM, Nurse #8 stated, "Told by nurse in training could give meds [medications] one hour before or after scheduled time." Nurse #8 confirmed that she administered the insulin at 4:19 PM.


Observations in RR #4's room on 2/7/11 at 4:50 PM, Nurse #2 administered Ferrous Sulfate 220mg/5ml (7.5 ml) to RR #4. The failure to administer the correct dosage of Ferrous Sulfate to RR #4 resulted in medication error #3.

4. All Licensed Nurses will be in-serviced by Clinical Pharmacy Liaison/Pharmacy Consultant/DON/SDC on types of insulin/onset times.

All Licensed Nurses and Dietary staff will be in-serviced by DON/SDC/designee on delivery of meal tray within 15-30 minutes of administration of insulin.

Newly hired Licensed Nurses and Dietary staff will receive above in-service as part of orientation.

Meal trays of residents on insulin will be sent out first to Dining room or to floor.

After performing accuchek, Licensed Nurse will ensure that meal is available before administering insulin.

Meal tray will be delivered within 15-30 minutes of administering insulin depending on onset of type of insulin.

DON/SDC/designee will monitor meal delivery of residents on insulin to ensure that meal is delivered within 15-30 minutes depending on onset of
During an interview at the 100 hall nurses station on 2/8/11 at 7:00 PM, Nurse #2 confirmed that she gave the incorrect dosage of Ferrous Sulfate to RR #4.

6. Review of the facility's "Administering Medications through a Metered Dose Inhaler" policy documented, "...Allow at least one (1) minute between inhalations of the same medication and at least two (2) minutes between inhalations of different medications..."

Medical record review for RR #5 documented an admission date of 6/1/08 with a readmission date of 4/7/10 with diagnoses of Anxiety Disorder, Hyperlipidemia, Congestive Heart Failure, Diabetes Mellitus and Poisoning - Anticoagulants. Review of a physician's order dated 2/2/11 documented, "...SPIRIVA 30 CAPS [capsule] INHALE CONTENTS OF ONE CAPSULE ORALLY ONCE DAILY. TAKE TWO SEPARATE INHALATIONS... COMBIVENT 18-103MCG [micrograms] INHALE INHALE 2 PUFFS EVERY 6 HOURS..."

Observations in RR #6's room on 2/8/11 at 10:21 AM, Nurse #1 administered one inhalation of the Spiriva capsule to RR #6. Failure to administer two inhalations resulted in medication error #4.

Observations in RR #6's room on 2/8/11 at 5:25 PM, revealed Nurse #8 administered two puffs of a Combivent inhaler to RR #5. Nurse #8 did not pause between the puffs. Failure to pause at least one minute between puffs resulted in medication error #8.

During an interview in the restorative dining room...
Continued From page 13 on 2/8/11 at 6:50 PM, Nurse #3 stated, "Didn't know had to wait a minute between puffs."


Observations in RR #10's room on 2/8/11 at 4:48 PM, Nurse #3 administered two tablets of Tylenol 325 mgs to RR #10. The administration of the Tylenol 325 mgs resulted in medication error #6.

During an interview at the meadow's nurses station on 2/8/11 at 6:30 PM, Nurse #3 confirmed that there was not a current order for the Tylenol 325 mgs for RR #10.

8. Medical record review for RR #12 documented an admission date of 5/1/08 with a readmission date of 9/3/10 with diagnoses of Dementia, Hypertension, Chronic Renal Failure and Status Cardiac Pacemaker. Review of a physician's order dated 2/2/11 documented, "...CARVEDILOL 3.125MG TABLET-COREG 1 TAB BY MOUTH TWICE DAILY WITH MEALS..."

Observations on the 200 hall on 2/8/10 at 5:00 PM, Nurse #2 administered Coreg 3.125mgs to RR #12. The administration of the medication without a meal resulted in medication error #7.

During an interview at the 100 hall nurses station
<table>
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<tr>
<th>ID</th>
<th>PREFIX</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 332</td>
<td>Continued From page 14 on 2/8/11 at 7:00 PM, Nurse #2 stated, “Need to fix that [referring to Coreg and meals].”</td>
<td>F 332</td>
<td>1. The facility will ensure that residents are free of any significant medication errors.</td>
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<tr>
<td>F 333</td>
<td>SS=d</td>
<td>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</td>
<td>F 333</td>
<td>2. Resident #13 is receiving meal within 30 minutes of administration of insulin.</td>
<td></td>
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</tbody>
</table>

The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:
Based on review of "MED-PASS COMMON INSULINS" provided by the America Society of Consultant Pharmacist, medical record review, observations and interviews, it was determined 2 of 6 nurses (Nurses #2 and 8) failed to ensure residents were free of significant medication errors when insulin administration was not correlated with meals.

The findings included:
1. Review of the "MED-PASS COMMON INSULINS; Pharmacokinetics, compatibility, and properties" provided by the America Society of Consultant Pharmacist for typical dosing administration of insulin related to meals documented, "...Novolin R [Regular] ...ONSET [in hours unless noted] 0.5 - [to] 1... TYPICAL DOSING / COMMENTS... give 30 minutes before meals..."

2. Medical record review for Resident #13 documented an admission date of 9/19/08 with a readmission date of 11/16/08 with diagnoses of Convulsions, Hyperlipidemia, Hypertension and Diabetes Mellitus. Review of a physician's order dated 2/2/11 documented, "...NOVOLIN R 100U [units] / [per] 1ML [milliliter] UNIT SSI [sliding
<table>
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<tr>
<th>F 333</th>
<th>Continued From page 15 scale insulin 200 - 300 4 UNITS SUB-Q [subcutaneous].</th>
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<tbody>
<tr>
<td></td>
<td>Observations in Resident #13's room on 2/7/11 at 4:15 PM, Nurse #2 administered 4 units of Novolin R to Resident #13. Resident #13 did not receive her meal until 5:20 PM. The administration of the Novolin R insulin more than 30 minutes before Resident #13 was served supper resulted in a significant medication error.</td>
</tr>
</tbody>
</table>
|        | During an interview on the 100 hall on 2/8/11 at 7:00 PM, Nurse #2 stated, "The time frame is 30 minutes before meals."
| 3.     | Medical record review for Random Resident (RR) #9 documented an admission date of 6/25/10 with diagnoses of Congestive Heart Failure, Diabetes Mellitus and Hypertension. Review of a physician's order dated 2/2/11 documented, "...NOVOLIN R 100U/ML UNIT SSI: 200-300 = [amount of insulin to be administered] 4 UNITS, 301-400 = 6 UNITS..."
|        | Observations in RR #9's room on 2/8/11 at 4:19 PM, Nurse #8 administered 8 units of Novolin R to RR #9. RR #9 did not receive his meal tray until 6:20 PM. The administration of the Novolin R more than 30 minutes before RR #13 received his supper resulted in a significant medication error. |
|        | During an interview in the restorative dining room on 2/8/11 at 6:49 PM, Nurse #3 stated, "Told by nurse in training could give meds [medications] one hour before or after scheduled time." Nurse #3 confirmed she administered the insulin at 4:19 PM.

<table>
<thead>
<tr>
<th>F 431</th>
<th>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Newly hired Licensed Nurses and Dietary staff will receive above in-service as part of orientation.</td>
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<td>Meal trays of residents on insulin will be sent out first to Dining room or to floor.</td>
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<tr>
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<td>After performing accuchek, Licensed Nurse will ensure that meal is available before administering insulin.</td>
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<tr>
<td></td>
<td>Meal tray will be delivered within 15-30 minutes of administering insulin depending on onset of type of insulin.</td>
</tr>
<tr>
<td></td>
<td>DON/SDC/designee will monitor meal delivery of residents on insulin to ensure that meal is delivered within 15-30 minutes depending on onset of type of insulin.</td>
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<tr>
<td></td>
<td>5. Results of monitoring will be presented to the facility Quality Assurance Committee monthly x 3 months to assess effectiveness of system.</td>
</tr>
</tbody>
</table>
GALLAWAY HEALTHCARE CENTER

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>F 431</td>
<td>Continued From page 16</td>
<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 controlled drugs is maintained and periodically reconciled.</td>
<td>1. Facility will employ or obtain the services of a licensed pharmacist who establishes a system to ensure that internal and external medications are stored separately; medications are not stored past open/expiration dates; multi-dose containers are dated when opened.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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.</td>
<td>2. Corrections have been made in the areas identified including storing of internal and external medications separately, removal of expired medications and removal of multidose vials not dated when opened.</td>
</tr>
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<td></td>
<td></td>
<td>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.</td>
<td>3. Internal and external medications are being stored separately; medications are not being stored past open/expiration dates; multidose containers are being dated when opened.</td>
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<td>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.</td>
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</tbody>
</table>

This REQUIREMENT is not met as evidenced by:
Based on policy review, observations and interviews, it was determined the facility failed to
F 431 Continued From page 17

ensure internal and external medications were stored separately in 1 of 5 (meadow's medication room) medication storage areas; medications were not stored past their open/expiration date in 4 of 5 (meadow's medication cart, 100 hall medication cart, 100 hall medication room and 200 hall medication cart) medication storage areas and a multi-dose vial was dated when opened in 1 of 5 (100 hall medication room) medication storage areas.

The findings included:

1. Review of the facility's "Storage of Medications" policy documented, "...Drugs for external use... shall be clearly marked as such, and shall be stored separately from all other medications..."

Observations in the meadow's medication room on 2/9/11 at 9:20 AM, revealed the following internal and external medications stored together:

- icy/hot cream (external)
- Megace liquid (internal)
- Vick's Vapor Rub (external)
- Foot soap (external)
- Ben-Gay (external)

During an interview in the meadow's medication room on 2/9/11 at 9:25 AM, Nurse #8 confirmed that the internal and external medications were stored together.

2. Review of the facility's "Storage of Medications" policy documented, "...The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals...

a. Observations of the meadow's medication cart

F 431 4. All Licensed Nursing staff has received in-service by DON/SDC/designee on storing of internal and external medications separately, medications not being stored past open/expiration dates and dating of multi-dose container when opened.

Newly hired Licensed Nursing staff will receive the above in-service as part of orientation.

DON/SDC/designee will monitor medication rooms and carts weekly x 4 weeks.

Pharmacy Consultant will monitor medication rooms and carts monthly during scheduled visits.

5. Results of the above audits will be presented to the Quality Assurance committee monthly x 3 months to assess effectiveness of system.
Continued From page 18

on 2/9/11 at 9:15 AM, a vial of Levenir insulin was stored past an open date of 12/26/10.

b. Observations of the 100 hall medication cart on 2/9/11 at 12:55 PM, a vial of Diazepam 10 milligrams/ml/11 liter stored past the expiration date of September 1, 2010.

During an interview in the 100 hall on 2/9/11 at 12:55 PM, Nurse #1 stated, "We'll get it [referring to Diazepam] taken off the cart today."

c. Observations in the 100 hall medication room on 2/9/11 at 1:10 PM, revealed the following medications stored past their open/expiration date:
   a. Tuberculin with an open date of 10/12/10.
   c. Tuberculin with an open date of 8/3/10.
   d. Tuberculin with an open date of 11/30/10.

During an interview in the 100 hall medication room on 2/9/11 at 1:15 PM, Nurse #1 confirmed that the above listed medications were stored past their open/expiration date.

d. Observations in the 200 hall on 2/9/11 at 1:20 PM, revealed the 200 hall medication cart contained the following medications stored past their expiration date:
   b. Banophen oral solution, with an expiration date of 1/11.

3. Review of the facility's "Administering Medications" policy documented, "...When opening a multi-dose container, the date shall be recorded on the container..."
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 431</td>
<td>Continued From page 19 Observations in the 100 hall medication room on 2/8/11 at 1:10 PM, revealed a vial of Tuberculin that was not dated when opened.</td>
<td>F 441</td>
<td>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.</td>
<td>03/11/11</td>
</tr>
<tr>
<td>F 441</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.</td>
<td>F 441</td>
<td>2. Nurses # 2, 3, 4, 5, 7, 8 have been in-serviced and are cleaning glucometer per manufacturer's instructions before and after use.</td>
<td>03/11/11</td>
</tr>
<tr>
<td></td>
<td>(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.</td>
<td></td>
<td>RR #13, 2, 3, 5, 4, 9-glucometers are being cleaned by Licensed Nurse per manufacturer's instructions before and after use.</td>
<td>03/11/11</td>
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<tr>
<td></td>
<td>(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.</td>
<td></td>
<td>Nurses #1, 6-have been in-serviced on installation of eye drops and are administering eye drops per policy.</td>
<td>03/11/11</td>
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<tr>
<td></td>
<td>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of</td>
<td></td>
<td>RR #1-is being administered dye drops per facility policy.</td>
<td>03/11/11</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Nurse #3, 6-have been in-serviced on hand washing policy and procedure when administering medications.</td>
<td>03/11/11</td>
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</table>
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>F 441</td>
<td>Continued From page 20 infection.</td>
<td>F 441</td>
<td>CNA #2, have been in-serviced on hand washing policy and procedure during meal tray delivery and meal trays are being delivered using appropriate infection control procedures.</td>
<td></td>
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</table>

3. Glucometers are being cleaned before and after use for each resident per manufacturer's instructions. Eye gts are being administered per facility policy. Hand washing is being done during medication pass and meal tray pass per facility protocol.

4. All Licensed Nursing staff will be in-serviced by the Clinical Pharmacy liaison/Pharmacy Consultant/DON/SDC on procedure for cleaning glucometers before and after use; procedure for administration of eye drops using proper Infection control techniques; and hand washing during medication pass.
<table>
<thead>
<tr>
<th>F 441</th>
<th>Continued From page 21</th>
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</thead>
<tbody>
<tr>
<td>a. Observations in Resident #13’s room on 2/7/11 at 4:15 PM, Nurse #2 performed a Fingerstick Blood Glucose (FSBS) on Resident #13. Nurse #2 did not clean the glucometer after use.</td>
<td></td>
</tr>
<tr>
<td>b. Observations in Random Resident (RR) #2’s room on 2/7/11 at 4:30 PM, Nurse #3 performed a FSBS on RR #2. Nurse #3 did not clean the glucometer after use.</td>
<td></td>
</tr>
<tr>
<td>c. Observations in RR #3’s room on 2/7/11 at 4:37 PM, Nurse #4 performed a FSBS on RR #3. Nurse #4 did not clean the glucometer before or after use.</td>
<td></td>
</tr>
<tr>
<td>During an interview at the 100 hall nurses station on 2/9/11 at 8:15 AM, Nurse #4 stated, &quot;Suppose to clean it [glucometer] after each use.&quot;</td>
<td></td>
</tr>
<tr>
<td>d. Observations in RR #2’s room on 2/9/11 at 11:18 AM, Nurse #5 performed a FSBS on RR #2. Nurse #5 cleaned the glucometer with an alcohol swab before and after use.</td>
<td></td>
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<tr>
<td>e. Observations in RR #5’s room on 2/8/11 at 10:30 AM, Nurse #7 performed a FSBS on RR #5. Nurse #7 did not clean the glucometer before or after use.</td>
<td></td>
</tr>
<tr>
<td>Observations in RR #4’s room on 2/8/11 at 10:45 AM, Nurse #7 performed a FSBS on RR #4. Nurse #7 did not clean the glucometer before or after use.</td>
<td></td>
</tr>
<tr>
<td>During an interview at the 100 hall nurses station on 2/9/11 at 9:40 AM, Nurse #7 stated, &quot;They generally clean it [glucometer] before shift starts.&quot;</td>
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<tr>
<td>f. Observations in RR #9’s room on 2/8/11 at 4:10</td>
<td>F 441</td>
</tr>
<tr>
<td></td>
<td>All CNA’s will be in-serviced by DON/SDC/designee on hand washing during meal tray delivery.</td>
</tr>
<tr>
<td></td>
<td>Newly hired CNA’s will receive above in-service as part of orientation.</td>
</tr>
<tr>
<td></td>
<td>DON/SDC/Designee will observe random Licensed Nurses during performance of accuchek weekly x 4 weeks for cleaning of glucometers before and after use.</td>
</tr>
<tr>
<td></td>
<td>DON/SDC/Designee will observe random nurses weekly x 4 weeks during installation of eye drops for use of appropriate infection control techniques.</td>
</tr>
<tr>
<td></td>
<td>DON/SDC/Designee will observe random nurses for hand washing during medication pass weekly x 4 weeks.</td>
</tr>
<tr>
<td></td>
<td>DON/SDC/Designee will observe random CNA’s during meal tray pass for hand washing weekly x 4 weeks.</td>
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</tbody>
</table>
Continued From page 22

PM, revealed Nurse #8 performed a FSBS on RR #9's. Nurse #8 cleaned the glucometer with an alcohol swab before and after use.

2. Review of the "Instillation of Eye Drops" policy documented, "...Drop the medication into the mid lower eyelid (forrix). Note: Do not touch eye or eyelid with the dropper.) Recap the medication bottle..."

a. Observations in Random Resident #1's room on 2/7/11 at 2:00 PM, Nurse #1 placed the top of the eye drop container in a downward position on the overbed table.

During an interview at the 100 hall nurses station Nurse #1 stated, "I should have placed it [eye dropper] upward."

b. Observations in RR #1's room on 2/8/11 at 10:00 AM, Nurse #6 administered eye drops to RR #1. While administering the eye drops in RR #1's left eye, the tip of the eye dropper touched RR #1's eye and eyelid. Nurse #6 proceeded to instill eye drops in RR #1's right eye, the tip of the eye dropper touched RR #1's eye and eyelid.

During an interview at the 100 hall nurses station on 2/8/11 at 8:50 AM, Nurse #6 confirmed that the tip of the eye dropper touched the residents eye and eyelid.

3. Observations in Random Resident (RR) #2's room on 2/7/11 at 4:30 PM, Nurse #3 performed a FSBS on RR #2. Nurse #3 did not wash her hands.

4. Observations in RR #1's room on 2/8/11 at 10:00 AM, Nurse #6 administered eye drops to

5. Results of observations will be presented to the facility QA committee monthly x 3 months to assess effectiveness of system.
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<td>F 441</td>
<td></td>
<td></td>
<td>Continued From page 23</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>RR #1. Nurse #6 did not wash her hands or change gloves between instillation of the eye drops in RR #1's left and right eyes.</td>
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<td></td>
<td>5. Observations during the food tray pass in RR #6's room on 27/11 at 6:07 PM, CNA #2 carried the food tray into the room, took it back to the cart, went into room 122 and brought out that resident's overbed table and put it in room 121 and brought the food tray back into the room and placed it on the table in front of the resident without washing or disinfecting the overbed table before letting another resident use it.</td>
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<tr>
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<td></td>
<td>6. Observations during the food tray pass in RR #14's room on 28/11 at 12:04 PM, CNA #1 picked up a plate cover that had fallen on the floor and continued to set up RR #14's food, opened her straw and spice packets without washing her hands.</td>
</tr>
</tbody>
</table>