**MAURY REGIONAL HOSPITAL SNU**

<table>
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<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PROCESSED BY FULL REGULATORY OR LSC 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>(X5) COMPLETION DATE</th>
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| F 241 SS=D         | **483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY**<br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on review of the "Medication Guide for the Long-Term Care Nurse" and observations, it was determined 2 of 2 (Nurse #1 and 2) nurses failed to maintain residents' dignity and respect by entering residents' rooms without knocking or gaining permission to enter.<br><br>The findings included:<br>1. Review of the "Medication Guide for the Long-Term Care Nurse," Sixth Edition, page 68, documented, "Medication Administration in Nursing Facilities ...11. The nurse should knock on the resident's door before the..."

2. Observations outside room 108 on 2/7/11 at 11:35 AM, Nurse #1 entered Resident #5's room without knocking or gaining permission to enter.

Observations outside room 109 on 2/7/11 at 6:20 PM, Nurse #1 entered Resident #1's room without knocking or gaining permission to enter.

3. Observations outside room 101 on 2/8/11 at 12:06 PM, Nurse #2 entered Resident #2's room without knocking or gaining permission to enter. | F 241 | All nurses will in-service on the importance of knocking on door and waiting for response of patient to allow entry.<br>Specific nurses who did not meet guideline will be counseled.<br><br>For quality assurance, DON and unit coworkers will conduct random audits regarding staff's continuing to wait on response before entering room.<br><br>DON will be responsible for monitoring the deficient practice monthly for a total of six months and as needed ongoing. | 3/5/11 |
| F 371 SS=D         | **483.35(l) FOOD Procure, Store/Prepare/Serve - Sanitary** | F 371 | | 3/11/11 |

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 discloseable 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 discloseable 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**

**NAME OF PROVIDER OR SUPPLIER:**
MAURY REGIONAL HOSPITAL SNU

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
1224 TROTWOOD AVE
COLUMBIA, TN 38401

**DATE SURVEY COMPLETED:**
02/08/2011

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<td>F 371</td>
<td>Continued From page 1</td>
<td>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</td>
<td>F 371</td>
<td>Revise existing Policy #16-500-4 Uniform Dress Code bullets 5&amp;6 to reflect the revised procedures on hair restraints for staff. (see attached policy)</td>
<td>2/25/11</td>
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<td>Have beard guards and hair restraints available for staff at all times.</td>
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<td>Inservce all employees on revised policy.</td>
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<td>Director and Asst Dir of food and nutrition will follow up daily, on staff compliance with policy.</td>
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<td>Include this item on monthly sanitation check sheet to ensure that employees are following the policy. Employees found not following the policy will be subject to corrective action.</td>
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<td>Director &amp; Asst Dir of food &amp; nutrition will monitor the use of hair restraints, daily, weekly, and monthly for 3 months to ensure continued compliance.</td>
<td>2/25/11</td>
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MAURY REGIONAL HOSPITAL SNU

F 371
Continued From page 2

3. Observations in the kitchen on 2/7/11 at 2:25 PM, DSM #3 and #5 were walking throughout the kitchen wearing a cap, that did not completely cover their hair. DSM #4 was walking throughout the kitchen with his hair and beard not covered.

4. Observations in the kitchen on 2/8/11 at 11:25 AM, DSM #6 was obtaining food temperatures wearing a chef hat. DSM #6's hair and beard were not covered. The DM was walking throughout the kitchen with a cap on that did not completely cover his hair.

5. During an interview in the kitchen on 2/7/11 at 2:35 PM, DSM #5 stated, "We routinely wear baseball caps and not hair covers. Will fix this immediately."

During an interview in the kitchen on 2/8/11 at 11:45 AM, the DM stated, "...we have always worn ball caps. Will be a big change [completely covering hair and beards] for us..."

F 431
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
**F 431** Continued From page 3 applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

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

Based on policy review, observation and interview, it was determined the facility failed to ensure medications were not left unattended in 1 of 10 (room 107) resident rooms.

The findings included:

Review of the facility's medication storage policy documented "...assure the proper safe handling, security, and storage of medications... Procedure: 1. Keep medications in the automated dispensing machine or designated medication room of the patient care area."

Observations in room 107 on 2/7/11 at 10:45 AM, revealed a medication cup with an orange liquid substance on the bedside table in room 107.

**F 431**

All nurses will in-service on the importance of making sure that medications are not left unattended at the patient's bedside.

For quality assurance, ongoing training will be given to all nurses no less than yearly by DON.

Specific nurse who did not meet the guideline will be counseled separately.

DON will be responsible for monitoring the deficient practice monthly for a total of six months and as needed ongoing.

Completion Date: 3/5/11
Continued from page 4

During an interview outside of resident room 107 on 2/7/11 at 10:45 AM, Nurse #1 stated the orange liquid substance was "resident's [Resident #3's] Lactulose. Tried to give it to her earlier. I did not mean to leave that [Lactulose medication] there."

F 441
483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

All staff will receive in service regarding hand washing policy and procedure.
Ongoing training will be give to all staff no less than yearly by DON.
Specific nurse who failed to meet the guideline will be counseled.
For quality assurance, the Infection Control Department and unit co-workers will conduct random audits of staff for hand washing to ensure compliance with policy.
DON will be responsible for monitoring the deficient practice bi-weekly for a total of 3 months and as needed ongoing.

(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.
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<td>F 441</td>
<td>Continued From page 5</td>
<td>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</td>
<td>F 441</td>
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This REQUIREMENT is not met as evidenced by:

Based on review of the "Sorensen and Luckmann's Basic Nursing A Psychophysiologic Approach" and observations, it was determined 1 of 2 (Nurse #1) nurses failed to prevent the potential development or transmission of an infection by failing to wash her hands and turned the water off with her bare hands.

The findings included:

Review of the "Sorensen and Luckmann's Basic Nursing A Psychophysiologic Approach", Third Edition, page 518 through (-) 519, documented "Handwashing... 7. Thoroughly dry hands with paper towel. 8. Unless foot or knee control are being used, use paper towel to turn off water faucet."

Observations in Random Resident #1's room on 2/7/11 at 10:35 AM, Nurse #1 did not wash her hands or use hand sanitizer before administering medications.

Observations in Resident #5's room on 2/7/11 at 11:35 AM, Nurse #1 cleaned the accuchek machine, washed her hands and turned the faucet off with her bare hands. After obtaining the resident's blood, Nurse #1 removed her gloves, washed her hands and turned the faucet off with...
Continued From page 6
her bare hands.