<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LBG 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>COMPLETE DATE</th>
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<tbody>
<tr>
<td>N 629</td>
<td>1200-8-6-06(3)(b)8. Basic Services (3) Infection Control. 8. Water pitchers, glasses, thermometers, emesis basins, douche apparatus, enema apparatus, urinals, mouthwash cups, bedsprings and similar items of equipment coming into intimate contact with residents shall be disinfected or sterilized after each use unless individual equipment for each is provided and then sterilized or disinfected between residents and as often as necessary to maintain them in a clean and sanitary condition. Single use, resident disposable items are acceptable but shall not be reused.</td>
<td>N 629</td>
<td>Residents Affected Director of Nursing Services immediately in-serviced nursing staff involved regarding infection control policy including cleaning equipment between residents, wearing gloves for fingersticks and dressing change policy. Residents Potentially Affected All residents have the potential to be affected. Nursing staff to receive in-service regarding infection control policy, including cleaning equipment between residents. Licensed nursing staff to receive in-service regarding dressing change policy and wearing gloves when obtaining fingersticks. Measures/Systemic Changes Blood pressure cuffs will be cleaned between resident's and staff in-serviced on procedure. Department heads will monitor for infection control during &quot;Non-Clinical Rounds&quot;.</td>
<td>2/21/10</td>
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This Rule is not met as evidenced by: Type C Pending Penalty #31 1200-8-6.06(3)(b)8

Tennessee Code Annotated 68-11-804(c)31: All nursing homes shall disinfect contaminated articles and surfaces, such as mattresses, linens, thermometers and oxygen tents.

This Rule is not met as evidenced by: Based on policy review, observation and interview, it was determined 3 of 5 (Nurses #1, 2 and 4) nurses failed to maintain acceptable infection control practices by not cleaning equipment between sampled Residents #2, 8 and Random Resident (RR) #1 and 1 of 1 treatment nurse (Nurse #5) contaminated supplies during a dressing change for Resident #5 and failed to create a clean field during a dressing change for RR #3.
Monitoring Changes

Wound care observations by DNS or designee will occur one time weekly for the next three months. DNS or designee will complete daily rounds to observe for staff following infection control policy including cleaning equipment between residents and wearing gloves as appropriate. Findings will be reported in QAA for three months and action plans will be developed as indicated.

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<td>N629</td>
<td>Continued From page 1</td>
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<td>The findings included:</td>
<td>N629</td>
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<td>1. Review of the facility's policy titled &quot;Introduction Infection Control in Long-Term Care. ... Prevention of Infection... educating staff and ensuring that they adhere to proper techniques and procedures... These guidelines should apply to all potential sources of contact, including work-related exposure to residents with skin, respiratory, blood borne, enteric and other infections...&quot;</td>
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<td>2. Observations in Resident #2's room on 1/20/10 at 7:38 AM, revealed Nurse #2 checked the Resident #2's blood pressure with a wrist blood pressure machine. Nurse #2 took the blood pressure machine out of Resident #2's room and put it in a case and locked it in the medication cart. Nurse #2 did not clean the blood pressure cuff after use.</td>
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<td>3. Observations in Resident #8's room on 1/20/10 at 9:07 AM, revealed Nurse #4 took the blood pressure cuff from the medication cart and placed it on Resident #8's left wrist. After taking the blood pressure, Nurse #4 took the blood pressure cuff out of the room and put it in a case on the medication cart. Nurse #4 did not clean the blood pressure cuff after use. During an interview on the 500 hall on 1/20/10 at 9:20 AM, Nurse #4 stated, &quot;if they have sores or something, I'll clean [the blood pressure cuff] between patients.&quot;</td>
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<td>4. Observations in RR #1's room on 1/19/10 at 4:50 PM, revealed Nurse #1 wiped RR #1's right thumb with an alcohol prep pad. Using a lancet, Nurse #1 obtained a drop of blood and touched</td>
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The glucose monitoring strip to the blood. Nurse #1 set the glucose monitoring machine on the roommate's overbed table and applied an alcohol prep pad to the resident's thumb. Nurse #1 was not wearing gloves and RR #1's blood was on the alcohol prep pad. At 5:02 PM, Nurse #1 was observed to place the glucose machine in the medication cart. Nurse #1 did not clean the glucose machine after using it. Nurse #1 re-entered the room and removed the alcohol prep pad which had blood on it and disposed of it in the garbage can in the room. Nurse #1 did not wear gloves while doing the blood glucose testing or when removing the bloody alcohol prep pad.

5. Review of the facility's "Dressing Change, Clean" policy documented, "PURPOSE... To prevent infection and spread of infection... Create clean field with paper towels or towelette [towelette] drape..."

Observations outside RR #3's room on 1/19/10 at 3:05 PM, Nurse #5 removed a pair of scissors from her pocket and cut a piece of Xeroform dressing. Nurse #5 did not clean the scissors. Upon entering RR #3's room, Nurse #5 placed the clean supplies for the dressing change on an overbed table without cleaning the table or covering the table.

6. Observation during a dressing change in Resident #5's room on 1/20/10 at 9:30 AM, revealed Nurse #5 dropped the skin prep on the floor; picked up the skin prep from the floor and placed it on the clean area with other supplies on the overbed table (contaminating the supplies on the table)... with gloved hands Nurse #5 opened the skin prep she had picked up from the floor, wiped around the area with the gloves she had used to open the skin prep.