N 629

1200-8-6-08(3)(b)8. Basic Services

(3) Infection Control.

B. Water pitchers, glasses, thermometers, emesis basins, douche apparatus, enema apparatus, urinals, mouthwash cups, bedpans 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.

This Rule is not met as evidenced by:

N 629
This is a Pending Type C Penalty #31. Tennessee Code Annotated 68-11-604(c)(31):
All nursing homes shall disinfect contaminated articles and surfaces, such as mattresses, linens, thermometers and oxygen tents.

Based on observation and interview, it was determined the facility failed to ensure practices to prevent the potential spread of infection was maintained by properly cleaning and storing scissors used for wound care during 1 of 2 dressing changes.

The findings included:

Observations in the 100 hallway on 8/2/11 at 10:15 AM, revealed Nurse #1 cleaned a pair of scissors with an alcohol wipe and placed on top of the medication cart. Nurse #1 then gathered

N 629

8-22-11

Christian Care Center of Springfield believes its current practices were in compliance with the applicable standard of care, but In order to respond to this citation from the surveyor, the facility is taking the following additional actions:

Corrective Action for Targeted Residents:
Practices to prevent the potential spread of infection are currently in place for Random Resident (RR) #1.
Scissors used during dressing changes are being cleaned and stored properly.
Nurse #1 was educated on proper cleaning and storage of scissors on 8-3-11 by the DON. Direct observation of dressing change procedure of Nurse #1 by the ADON demonstrated proper infection control procedures for cleaning and storage of scissors on 8-3-11 and again on 8-10-11.

Identification of Other Residents with Potential to be Affected:
Current residents who require treatments that utilize scissors have the potential to be affected by this practice.

Systematic Changes:
In-service training on proper cleaning and storage of scissors was implemented on 8-3-11 for licensed nursing staff and will be completed by 8-22-11 by the ADON. Newly hired licensed nurses will complete dressing change observations during orientation and then annually by the Unit Manager or Treatment Nurse. Nurses who perform dressing changes will be monitored for proper procedure for infection control by the ADON monthly for three months.
N 629  
Continued From page 1  
all other supplies and entered Random Resident (RR) #1's room to perform a dressing change. Nurse #1 placed the scissors and other supplies on the barrier on the overbed table. After changing the dressing to the sacral area, Nurse #1 used the scissors to slit the tegaderm dressing covering the wound on the sacrum for the wound vac. Nurse #1 cleaned the scissors with an alcohol wipe and placed the scissors in her pocket.

During an interview in the 100 hallway on 8/3/11 at 10:20 AM, Nurse #1 was asked what was the facility protocol for cleaning of scissors between use. Nurse #1 stated, "Clean scissors with a bleach wipe. I couldn't find my bleach wipes yesterday, but I have them today."

During an interview in the 100 hallway on 8/3/11 at 10:50 AM, Nurse #1 was asked what was the facility protocol for storage of scissors between use. Nurse #1 stated, "I have my own pair of scissors I keep in my pocket and I just forgot and put the ones I used for the treatment in my pocket. [Scissors] Should be stored in the cart."

During an interview in the Director of Nursing's (DON) office on 8/3/11 at 11:00 AM, the DON was asked what is the facility protocol for cleaning and storing of equipment such as scissors. The DON stated, "Clean scissors between uses, before and after each resident, with chloride bleach wipe and store in the cart."

N 645  
**1200-8-6-08(3)(k) Basic Services**

(3) Infection Control.

(k) Space and facilities for housekeeping equipment and supply storage shall be provided.
<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>N 645</td>
<td>Continued From page 2</td>
<td>N 645</td>
<td>Correction Action for Targeted Residents:</td>
<td>8-22-11</td>
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<td></td>
<td>In each service area. Storage for bulk supplies and equipment shall be located away from patient care areas. The building shall be kept in good repair, clean, sanitary and safe at all times.</td>
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<td>The facility is currently providing a safe, functional, sanitary and comfortable environment for residents, staff and the public. Substance was removed from inner plastic pipe on bottom of shower chair, shower bench seat grooved area and stand up lift foot rest area by Housekeeping Director on 8-3-11. Stainless steel shelf identified as needing cleaning was cleaned and disinfected by the Housekeeping Director on 8-3-11 but some black spots could not be removed so the shelf was replaced with a new shelving unit 8-10-11 by the Maintenance Director.</td>
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<td>This Rule is not met as evidenced by:</td>
<td></td>
<td>Identification of Other Residents with Potential to be Affected:</td>
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<td></td>
<td>Pending Type C Penalty #19. Tennessee Code Annotated 68-11-804(e)19: The nursing home shall be clean and sanitary and in good repair at all times.</td>
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<td>Current residents have potential to be affected by this practice.</td>
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<td>Based on policy review, observation and interview, it was determined the facility failed to ensure the environment was clean and sanitary as evidenced by a large clump of black/brown substance on the inner plastic pipe near the seat of the mauve shower chair, quarter size brown substance smear on the shower bench seat and a puddle of brown stain on the stand up lift foot rest, large amount of black substances on the stainless steel shelf in 2 of 3 (back hall women’s and back hall men’s) shower rooms.</td>
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<td>The findings included:</td>
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<td>1. Review of the facility's &quot;Exposure Control Plan&quot; policy documented, &quot;...Cleaning of Reusable Equipment - Shower chairs are to be cleaned between use with hot, soapy water. They can be wiped with alcohol, Lysol and/or 1:10 household bleach solution if mixed within 24 hours of use time. Must be air dry...&quot;</td>
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<td>2. Observations in the back hall women’s shower room on 8/11/11 at 7:25 PM and 8/3/11 at 7:46 AM, revealed a puddle of brown stain on the foot rest of the stand up lift.</td>
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3. Observations in the middle hall on 8/2/11 at 8:05 AM, revealed a puddle of brown stain on the floor rest of the stand up lift.

4. Observations in the back hall women's shower room on 8/2/11 at 8:55 AM and 8/3/11 at 7:45 AM, revealed a black substance on the under seat and a large clump of black/brown substance on the inner plastic pipe near the seat of the mauve shower chair and a quarter size brown stain substance smear on the shower bench seat.

5. Observations in the back hall men's shower room on 8/2/11 at 9:00 AM and 8/3/11 at 7:50 AM, revealed a stainless steel shelf in the last shower stall with large amounts of black substances.

During an interview in the back hall women's shower room on 8/3/11 at 8:00 AM, the Director of Nursing (DON) was asked if the mauve shower chair, shower bench, and stand up lift were clean. The DON stated, "...I see it, could be BM [bowel movement]..."