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<th><strong>F 282</strong></th>
<th><strong>SUMMARY STATEMENT OF DEFICIENCIES</strong></th>
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<td><strong>SS=D</strong></td>
<td><strong>483.20(k)(3)(i) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</strong></td>
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The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident’s written plan of care.

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

Based on medical record review, observation and interview, it was determined the facility failed to follow interventions on the care plan for keeping protective stockings on all extremities at all times, floor mats beside the bed at all times when in the bed or spoon feeding the resident for 2 of 25 (Residents #1 and 6) sampled residents.

The findings included:

1. Medical record review for Resident #1 documented an admission date of 12/1/10 with diagnoses of Huntington’s Chorea, Diabetes, Vascular Dementia, Seizures, Pain, Mitral Valve Disorder, Dysphagia and Gastrostomy Feeding Tube. Review of the care plan dated 5/16/10 and updated 11/12/10 documented "...FLOOR MATS BESIDE BED AT ALL TIMES WHEN IN BED... KEEP PROTECTIVE STOCKINGS ON ALL EXTREMITIES AT ALL TIMES."

Observations in Resident #1’s room on 1/23/11 at 8:57 AM and 4:35 PM and on 1/24/11 at 7:45 AM and 8:50 AM, revealed Resident #1 did not have protective stockings on her arms or legs.

Observations on 1/23/11 at 9:57 AM, 4:35 PM, and on 1/24/11 at 7:45 AM, 8:50 AM, and 2:35 PM, revealed there were no floor mats beside the acceptable floor mats.

---

**LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**

Pamela Ominick  
**ADMINISTRATOR**

2/22/11

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.
F 282 Continued From page 1

bed on the floor.

During an interview in Resident #1’s room on 1/24/11 at 8:50 AM, Certified Nursing Assistant (CNA) #2 was asked if Resident #1 was wearing any protective stockings on her extremities. CNA #2 stated, "No..."

During an interview at the 300 hall nurses station on 1/24/11 at 9:00 AM, Nurse #15 was asked if Resident #1 should have protective stockings on her extremities when in the bed. Nurse #15 stated, "...yes ma’am she should..."

During an interview at the 300 hall nurses station on 1/24/11 at 2:30 PM, Nurse #10 was asked if Resident #1 had floor mats beside her bed. Nurse #10 stated, "...No, not since she has been in the Veil bed..."

During an interview in the conference room with the Director of Nursing (DON) on 1/24/11 at 4:00 PM, the DON stated, "yes" she expects the staff to follow the care plans.

The facility failed to follow the care plan to ensure that Resident #1 was wearing protective stockings when in the bed and that there were floor mats were on the floor beside the bed.

2. Medical record review for Resident #5 documented an admission date of 6/9/10 and a readmission date of 12/1/10 with diagnoses of Multiple Sclerosis, Hypertension, Peripheral Vascular Disease, Osteoporosis, Neurorgenic Bladder and Anemia. Review of the comprehensive care plan dated 6/9/10 and updated on 11/3/10 documented, "...SELF CARE DEFICIT... SPOON FEED ALL MEALS..." Review
**ST PETER VILLA DMHC**

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<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X) COMPLETION DATE</th>
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<tr>
<td>F 282</td>
<td></td>
<td>Continued From page 2 of the &quot;DAILY SKILLED NURSE'S NOTE&quot; dated 1/19/11 documented, &quot;...Comments / Concerns DAY shift... Can feed self after tray set-up...&quot; Resident #6's care plan was not revised to reflect the resident feeds herself. During an interview in Resident #6's room on 1/24/11 at 2:25 PM, Resident #6 was asked if someone helped her with lunch. Resident #6 stated, &quot;No. I feed myself.&quot; During an interview on the 300 hall on 1/25/11 at 8:40 AM, CNA #1 was asked if she assisted Resident #6 with meals. CNA #1 stated, &quot;We used to feed her when she was sick but now that she's better she wants to be independent. Now we just set up her tray.&quot;</td>
<td>F 282</td>
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<tr>
<td>F 309</td>
<td>F 308</td>
<td>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</td>
<td>F309</td>
<td></td>
<td>Signature HealthCare at St. Peter Villa will continue to ensure that each resident will receive and the 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. Immediate Interventions: 1. Orders clarified for documentation of safety checks for enclosure bed for resident #1 by 1/25/2011. Resident #1 and #12 were ensured to be wearing TED hose as ordered immediately 1/25/2011. Resident #1 and #6 care plans updated by care plan coordinator by 1/25/2011. Resident #13 and #14 weight orders were clarified by 1/25/2011.</td>
<td>1/25/2011</td>
</tr>
</tbody>
</table>

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 orders for Thrombo Embolic Deterrent (TED) Hose, visual checks every hour or weekly weights for 3 of 25 (Residents #1, 12 and 13) sampled residents.

The findings included:
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<th>ID</th>
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<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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</thead>
</table>
| F 309 | Continued From page 3 | 1. Medical record review for Resident #1 documented an admission date of 12/1/10 with diagnoses of Huntington's Chorea, Diabetes, Vascular Dementia, Seizures, Pain, Mitral Valve Disorder, Dysphagia and Gastrostomy Feeding Tube. Review of the physician's order dated 1/1/11 through 1/31/11 with an original order date of 12/24/09 documented, "...ENCLOSURE BED FOR RESIDENTS SAFETY DUE TO HUNTINGTON'S DISEASE VISUAL CHECK EVERY 1 HOUR..."  

Review of the medication administration record (MAR) dated 11/1/10 through 11/30/10 and 12/1/10 through 12/31/10 revealed there was no documentation of the hourly visual checks being performed on Resident #1. Review of the MAR dated 1/1/11 through 1/31/11 revealed there was no documentation of the hourly visual checks being performed 1/1/11 through 1/10/11.  

During an interview at the 300 hall nurses station on 1/24/11 at 9:00 AM, Nurse #15 was asked where the documentation for hourly checks ordered by the physician could be found. Nurse #15 stated, "should be on the MAR..."  

2. Medical record review for Resident #12 documented an admission date of 6/19/10 with diagnoses of Diabetes Mellitus Type II, Hypertension, Bradycardia, Coronary Artery Disease, Peripheral Vascular Disease and Amputation of Right Metatarsals. Review of a physician's order dated 1/1/11 documented, "...KNEE HI TED HOSE ON IN AM OFF IN PM..."  

Observations in Resident #12's room on 1/24/11 at 9:15 AM and 3:55 PM, revealed Resident #12 identified as the residents with potential to be affected:  
1. 100% audit of all residents with orders for TED hose by 2/4/2011 to ensure compliance by D.O.N. or designee with variance report to D.O.N. or administrator.  

100% audit of all care plans by MDS Coordinators by 2/20/2011 and monthly to ensure accuracy with clarifications as needed with results to D.O.N.  

100% resident records audited for appropriate weight orders by registered dietitian and nursing with clarifications by 1/27/2011.  

Measures to prevent reoccurrence:  
1. All nurses in-serviced on documentation of safety checks for enclosure bed for resident #1 by 2/2/2011.  

Nursing in-serviced to follow care plans and to ensure TED hose are applied as ordered by 2/20/2011.  

Nurses to be in-serviced on appropriate weight orders and documentation by 2/20/2011.  

Monitoring:  
1. Resident weight orders will be monitored monthly and pm by registered dietitian to ensure weight documentation as ordered with variance corrected immediately to D.O.N. and monthly to quality assurance committee effective 1/27/2011.  

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<tr>
<th>FEEDBACK ID</th>
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<td>F 309</td>
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<td>Residents with TED hosp orders will be monitored daily by nurse manager or designee for compliance with weekly audits effective 2/4/2011 and variances corrected and reported to quality assurance monthly. Care plan will be audited monthly and PMR for accuracy with immediate updating. All variances reported to DON ASAP and quality assurance committee monthly.</td>
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<td></td>
<td>F 309</td>
<td>Residents with TED hosp orders will be monitored daily by nurse manager or designee for compliance with weekly audits effective 2/4/2011 and variances corrected and reported to quality assurance monthly. Care plan will be audited monthly and PMR for accuracy with immediate updating. All variances reported to DON ASAP and quality assurance committee monthly.</td>
</tr>
<tr>
<td>F 322</td>
<td>SS-D</td>
<td>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</td>
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<td>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receive 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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Continued from page 5

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.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure staff administered medications via a Percutaneous Endoscopy Gastrostomy (PEG) Tube according to their policy for 1 of 1 (Resident #9) sampled residents during medication administration.

The findings included:

Review of the facility's "Tube Feeding Technique" policy documented, "...Flush tube before medication administration with 30 ml [milliliters] of water..."

Medical record review for Resident #9 documented an admission date of 8/3/10 and readmission date of 12/1/10 with diagnoses of Hip Fracture, Parkinson's Disease, Hypertension, Dementia and PEG tube. Review of a physician's order dated for 12/27/10 documented, "...SINEMET 10/100 1 TABLET PER PEG TUBE THREE TIMES A DAY..."

Observations in Resident #9's room on 1/23/11 at 3:50 PM, revealed Nurse #1 administered Sinemet 10/100 per PEG tube. Nurse #1 did not flush the PEG tube before administration of the medication.

Immediate Interventions:
1. Nurse #1 was in-serviced 1/28/2011 on peg tube medication administration that included flushing prior to medication administration with a return skills demonstration to D.O.N. or designee monthly and documentation of re-education as required by staff development, pharmacy, or D.O.N. designee.

Identification of the residents with potential to be affected:
2. 100% nurses in-serviced on peg tube medication administration including flushing prior to medication administration with return skills demonstration by 2/23/201, monthly and documentation by staff development and D.O.N. designee

Measures to prevent recurrence:
3. Monthly medication checks with all nurses with D.O.N. or designee to include peg tube medication administration with immediate correction of variance and results reported to D.O.N.

Monitoring:
4. Nursing management to monitor daily for compliance, to intervene as needed with re-education and training as necessary. Report all variances to D.O.N. D.O.N./designee reports findings to quality assurance monthly for appropriateness, effectiveness, and recommendations.
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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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>COMPLETION DATE</th>
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<td>F 322</td>
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<td>Continued From page 8 During an interview at the 400 hall nurses station on 1/23/11 at 4:55 PM, Nurse #1 was asked what she forgot to do before administration of the medication per PEG. Nurse #1 stated, &quot;...Forgot to flush first...&quot;</td>
<td>F 322</td>
<td></td>
<td>Signature HealthCare at St. Peter Villa will continue to ensure that each resident will receive proper treatment and care for the following special services: injections; parenteral and enteral fluids; colostomy, ileostomy, or enterostomy care; trachexcostomy care; tracheal suctioning; respiratory care; foot care; and prostheses. Immediate Interventions: 1. O2 rate corrected immediately for resident #8 to prescribed rate. Identification of the residents with potential to be affected:</td>
<td>1/25/2011</td>
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<tr>
<td>F 328</td>
<td>ss=d</td>
<td>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: injections; parenteral and enteral fluids; colostomy, ileostomy, or urostomy care; tracheostomy care; tracheal suctioning; respiratory care; foot care; and prostheses. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility failed to administer oxygen (O2) at the physician's prescribed rate for 1 of 5 (Resident #18) sampled residents. The findings included: Medical record review for Resident #18 documented an admission date of 6/18/10 and a readmission date of 12/23/10 with diagnoses of Urinary Tract Infection, Abdominal Pain due to Pancreatic Mass, Diabetes Mellitus, Hypertension, Chronic Obstructive Pulmonary Disease, Gastroesophageal Reflux Disease, Congestive Heart Failure and Hypothyroidism.</td>
<td>F 326</td>
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**ST PETER VILLA DMHC**

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<td>F 328</td>
<td>Continued From page 7</td>
<td>Review of a physician's order dated 12/30/10 documented &quot;...2 @ [at] 2 L [liters] / [per] m [minute] BNC[binal nasal cannula]...&quot; Observations in Resident #18's room on 1/23/11 at 9:30 AM and on 1/25/11 at 8:50 AM, revealed Resident #18 receiving 02 per BNC at a rate of 3.5 liters per minute, not the prescribed rate of 2L/m. During an interview in Resident #18's room on 1/25/11 at 8:55 AM, Nurse #10 stated, &quot;It's [oxygen] on 3.5 [liters per minute] but should be on 2 [liters per minute]&quot;</td>
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| F 386 | 483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS | The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. |

| F 386 | Signature HealthCare at St. Peter Villa will continue to ensure that the physician's write, date and sign orders for care, diagnostic tests, any medication, and treatment within 10 days. |

|  | Immediate Interventions: 1. Resident # 3's physician orders and recertifications were signed by their admitting physician by 1/25/11. Identifications of the residents with potential to be affected: 2. 100% all resident records were audited for physician signatures and timeliness completed by 1/22/11 with variances corrected with audit results to the Administrator, D.O.N, Medical Records, and Medical Director. Measures to prevent recurrences: 3. 100% all nursing staff to be invested on physician order process including telephone orders to be completed by 2/15/11. Monitoring: 4. Weekly physician order audits by nursing management and administrator designate for variances, immediate corrections and re-education as needed. All audit results will be reported to the quality assurance committee monthly to review effectiveness, appropriateness of interventions, and recommendations. |

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

141 N MCLEAN

MEMPHIS, TN 38104
F 386
Continued From page 8

Requirements for Patients in a Nursing Facility policy documented,
"...physician orders must be signed and
dated by the physician. If the physician is unable
to meet these timing requirements he/she may
request the facility medical director review and
sign the orders as a courtesy. Telephone
orders must be signed and dated by the
physician within ten (10) days of the order..."

Medical record review for Resident #3
documented an admission date of 2/1/06 with
diagnoses of Dementia, Oligivie Syndrome,
Alzheimer's, Hypertension, Gastroesophageal
Reflux Disease, Gout and Dysphagia. Review of
the physicians orders revealed the telephone
order and recertification orders were signed from
8/17/10 through 1/23/11.

During an interview at the 300 hall nurses station
on 1/23/11 at 2:20 PM, Nurse #2 was asked to
find Resident #3's most recent signed orders in
the chart. Nurse #2 stated, she was unable to find
any signed orders in the chart.

During an interview at the 300 hall nurses station
on 1/23/11 at 2:50 PM, Nurse #15 confirmed
there were no signed orders on the chart.

During an interview at the 300 hall nurses station
on 1/23/11 at 4:00 PM, the medical records
supervisor confirmed the 8/17/10 recertification
orders were the only signed orders from 8/17/10
through 1/23/11.

F 431
Signature Health Care at St. Peter Villa will continue
to 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.

F 431
483.90(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
**Summary Statement of Deficiencies**

(F431) Continued From page 9

- Records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

- Drugs and biological 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.

- 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.

**Provider's Plan of Correction**

(F431) Drugs and biologicals used in Signature Healthcare at St. Peter Villa will continue to be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

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

- Signature Healthcare at St. Peter Villa will continue to 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.

**Immediate Interventions:**

1. Nursing staff removed medication immediately from resident #2's bedside and properly stored it on 1/23/2011.

2. 100% resident rooms audited to ensure no meds at bedside on 1/23/2011 and weekly by D.O.N. or designee.

**Measures to Prevent Recurrence:**

3. Nursing staff in-services on ensuring no medications are at bedside on 2/20/2011, with nursing management to monitor daily to ensure compliance, re-educate as needed to report variances to D.O.N.

**Monitoring:**

4. Nurse manager/supervisor/designee to monitor daily for compliance with medication storage procedure with results to D.O.N. for review and D.O.N. or designee to report results monthly to quality assurance committee for effectiveness, appropriateness and recommendations.
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<th>ID</th>
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<tr>
<td>F431</td>
<td>Continued From page 10</td>
<td>The findings included:</td>
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Medical record review for Resident #2 documented an admission date of 1/27/10 with diagnoses of Congestive Heart Failure, Alzheimer's Dementia, Hypertension, Depression and Glaucoma. Review of a physician's order dated 1/19/11 documented, "Nystatin cream to scrotal area 3 x [times] day until healed for irritation." Observations in room 209 on 1/23/11 at 9:35 AM, revealed a tube of medication on Resident #2's bedside table labeled, "Nystatin 100,000 units/GM [gram]... apply to scrotal area 3 x day until healed... for external use only keep this and all medications out of the reach of children." There was no nurse in the room.

Observations in room 209 on 1/23/11 at 2:45 PM and 4:00 PM, revealed the tube of Nystatin remained on the bedside table with no nurse in the room.

During an interview on the 200 hall on 1/23/11 at 4:00 PM, Nurse #13 stated, "It's [Nystatin] not supposed to be off the cart [medication cart]... It [Nystatin] was probably left in there [room 209] by mistake by one of the nurses."

| F441 | SS=D | 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
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
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<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
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<tbody>
<tr>
<td>445139</td>
<td>A. BUILDING:</td>
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<td>B. WING:</td>
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<th>(X3) DATE SURVEY COMPLETED</th>
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<tr>
<td>01/26/2011</td>
<td>141 N MCLEAN</td>
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<td>MEMPHIS, TN 38104</td>
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**NAME OF PROVIDER OR SUPPLIER**

ST PETER VILLA DMHC

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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| F 441 | Continued From page 11 | 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. | |

**(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, observation and interview, it was determined 2 of 12 nurses (Nurses #2 and 3) failed to ensure that infection control practices were followed for handwashing and the cleaning of the blood glucose monitoring device during medication administration.

**(6) Prevention 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) Signature HealthCare at St. Peter Villa continues to 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) Signature HealthCare at St. Peter requires staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

**Immediate Interventions:**

1. Nurse #2 in-service on appropriate handwashing prior to applying gloves during medication administration on 1/27/2011 and monthly to ensure compliance by D.O.N. or designee with report to quality assurance committee for appropriateness, effectiveness and recommendations.

2. Nurse #3 in-service on appropriate handwashing with bleaching wipes per facility policy and return demo for glucometers on 1/27/2011 and monthly by D.O.N. or designee with report to quality assurance committee monthly for appropriateness, effectiveness, and recommendations.

3. 100% all nurses in-service on appropriate glucometer cleaning procedure with bleach wipes by 2/20/2011 and monthly by D.O.N. or designee with report to quality assurance committee monthly for appropriateness, effectiveness, and recommendations.

4. 100% all staff in-service on hand washing procedure prior to applying gloves with return demonstration 2/20/2011 by staff development, D.O.N. or designee.
F 441  Continued From page 12
The findings included:

1. Review of the facility's "Handwashing" policy documented, "...Purpose: To decrease the risk of transmission of infection by appropriate and washing... Policy: Handwashing is generally considered the most important single procedure for preventing nosocomial infections."

Observations in room 305 on 1/24/11 at 7:50 AM, Nurse #2 entered room 305, closed the door, pulled the privacy curtain and pushed the resident in a wheelchair to his side of the room. Nurse #2 then applied gloves and administered an inhaler to the resident. Nurse #2 did not wash her hands prior to applying gloves.

2. Review of the facility's "CLEANING BLOOD GLUCOSE MONITORING DEVICES" policy documented, "...[Facility's Name] aims to clean/disinfect equipment between residents to prevent infections... BLEACH WIPES (PDI-SANI-CLOTH) are supplied to each nursing unit to clean/disinfect the Glucose Monitoring Devices..."

Observations on the 200 hall on 1/23/11 at 4:40 PM and 4:50 PM, Nurse #3 cleaned the blood glucose monitoring machine between residents with an alcohol wipe. Nurse #3 did not clean the blood glucose monitoring device with a bleach wipe as per the facility's policy.

During an interview on the 200 hall on 1/23/11 at 4:50 PM, Nurse #3 was asked if she always cleaned the blood glucose monitoring device with alcohol wipes. Nurse #3 stated, "Yes."

F 502  PROVIDE/OBTAIN LABORATORY
SVC-QUALITY/TIMELY
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The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to ensure laboratory services were obtained as ordered by the physician for 1 of 25 (Resident #4) sampled residents.

The findings included:

Medical record review for Resident #4 documented an admission date of 12/28/09 and a readmission date of 1/6/11 with diagnoses of Dysphagia, Percutaneous Endoscopy Gastrostomy Tube Placement, Atrial Fibrillation, Hypothyroidism, Chest Wall and Shoulder Abscess with Methicillin-Resistant Staphylococcus Aureus and Anemia. Review of a physician's order dated 1/17/11 documented, "...Labs: CMP [Comprehensive Metabolic Panel], CBC [Complete Blood Count], Digoxin level in AM [morning]..." The facility was unable to provide documentation that the laboratory work was drawn as ordered by the physician.

During an interview at the 300 hall nurses station on 1/24/11 at 2:30 PM, Social Worker #1 verified that the laboratory work had not been completed as ordered by the physician.

Signature HealthCare at St. Peter Villa continues to obtain laboratory services to meet all the needs of its residents. Signature HealthCare at St. Peter Villa is responsible for the quality and timeliness of its services.

Immediate Interventions:
1. CMP, CBC, Digoxin levels were obtained for resident # 4 as ordered 1/26/11.

Identification of the residents with potential to be affected:
2. 100% resident charts audited to ensure all laboratory work ordered had been performed as ordered completed by 2/4/11.

Measures to prevent recurrence:
3. 100% nursing staff will be in-serviced on laboratory ordering procedures and laboratory monitoring process by 2/20/11.

4. Daily clinical meetings with physician laboratory orders reviewed by unit manager or D.O.N. designee effective immediately with daily auditing for accuracy by D.O.N. or designee.

Monitoring:
5. Monthly chart audits by D.O.N. or designee for laboratory order completion with immediate intervention for variances, re-education of nurses and results reported to quality assurance monthly to review for appropriateness and effectiveness of interventions along with recommendations.