SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR USC IDENTIFYING INFORMATION)

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 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:

Medication carts will be secured/locked when out-of-sight of the nurse administration medications.

Nurse #1 received 1 on 1 written counseling and re-education of the necessity of following established procedures during medication pass.

This counseling was performed by the Director of Nursing on 12/22/11.

To identify and prevent a re-occurrence of similar situation, mandatory inservices for all Nurses were given on, 12/27, & 12/28 on the topic of Medication Administration and Storage by the Director of Nurses. Pre-and post test were given to measure effectiveness of inservice.

Unannounced, med-pass observations will be conducted by the Director of Nursing on a weekly basis for the next three months and Pharmacy Consultant will conduct med-pass observations on a monthly basis to assure continued compliance of properly locking the medication carts. New hires will review Medication Administration and Storage policies and procedures as part of orientation by the Staff Development.

FORM CMS-2587(02-99) Previous Versions Obsolete
Event ID: 1YU411
Facility ID: TAN9101
If continuation sheet Page 1 of 4
Continued From page 1

Based on policy review, observation and interview, it was determined 1 of 5 (Nurse #1) nurses observed administering medications failed to keep medications secured, when then medication cart was left unlocked and out of sight.

The findings included:

Review of the facility's "Medication Storage in The Facility" policy documented, "MEDICATION ROOM AND CARTS SHOULD BE UNDER LOCK AND KEY AND ACCESSIBLE BY PERSONAL WHO HAVE AUTHORITY TO ACCESS."

Observations on A hall on 12/19/11 at 1:50 PM, Nurse #1 pulled medications from the medication cart, knocked on a residents door and entered the room. Nurse #1 left the medication cart unlocked and out of her sight while in a resident's room.

During an interview in the conference room on 12/20/11 at 10:00 AM, the Director of Nursing stated, "If the nurse goes into a room, turns her back, or is away from the cart she should lock it [medication cart]."

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
The facility must establish an Infection Control
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
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</thead>
<tbody>
<tr>
<td>445155</td>
<td>A. BUILDING:</td>
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<tr>
<td></td>
<td>B. WING:</td>
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</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER:**

MANOR HOUSE OF DOVER

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

537 SPRING STREET, PO BOX 399
DOVER, TN 37058

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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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<tbody>
<tr>
<td>F 441</td>
<td>Continued From page 2 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, medical record review and observation, it was determined the facility failed to ensure staff washed their hands during a dressing change for 1 of 2 (Resident #8) sampled residents. The findings included:</td>
<td>F 441</td>
<td>Facility will ensure staff follow proper handwashing procedures during dressing changes. Nurse #3 received documented counseling and re-education of the necessity of following established handwashing procedures when changing dressings. This counseling was conducted by the Director of Nursing on 1/06/12. To prevent a similar re-occurrence, mandatory inservices were given on 12/27/11 and 12/28/11 on the topic of “Aseptic Dressing Changes” for all Nurses. Pre and post testing was used to measure effectiveness of inservice and to ascertain all nurses were able to demonstrate proper procedure. All licensed personnel will review Infection Control and Aseptic Dressing Changes protocol as part of the Orientation given by the Staff Development Coordinator upon hire.</td>
<td>1/06/12</td>
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Random, unannounced, dressing change observations will be conducted weekly by the Director of Nursing for the next three months and monthly thereafter.

Results of the Infection Control Observations will be presented to the Continual Quality Improvement (CQI) Committee which meets monthly. The CQI Committee is composed of the Medical Director, the Administrator, the Director of Nursing, the Staff Development Coordinator, the Pharmacy Consultant, Risk Manager, Restorative Nurse, Social Worker, Activity Director and Dietary Manager. The CQI Committee will make recommendations to the Director of Nursing and develop plans of action if noncompliance is noted. The Director of Nursing will immediately implement any new plans of action recommended and report back to the CQI Committee for monitoring of for continued compliance.

Observations in Resident #8's room on 12/20/11 at 9:45 AM, Nurse #3 did a dressing change on Resident #8's left ankle. Nurse #3 removed the soiled dressing and discarded the soiled dressing and gloves into the plastic trash bag. Nurse #3 then applied another pair of gloves and proceeded to cleanse the wound. Nurses #3 did not wash her hands after removing the soiled dressing as per the facility policy.

Review of the facility's dressing change policy documented, "...8. Put on clean gloves. Loosen tape and remove soiled dressing. 9. Pull glove over dressing an discard into plastic or biohazard bag. 10. Wash and dry your hands thoroughly..."