F 159 F 159
483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS 483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS
SS=D SS=D

Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.

The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the

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<td>F 159 483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS SS=D</td>
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Requirement:
The facility will have personal funds available on ongoing bases.

Corrective Actions:

1. On 12/16/11 we set up a petty cash box for the nurses to give patients money after hours and on weekends.
2. On 12/16/11 Patients and staff were in-serviced on available funds after hours and weekends.
3. Payroll and bookkeepers will interview Residents weekly times 3 weeks then monthly to ensure they have funds available after hours and weekends.
4. Administrator, Payroll, and bookkeepers will monitor monthly for compliance and report findings to our QA&A Committee Quarterly.
Continued From page 1

resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:

Based on policy review and interview, it was determined the facility failed to ensure residents had access to petty cash on an ongoing basis and in the amount requested by resident for 3 of 10 (Residents #17, 23, and 28) sampled residents interviewed with a personal funds account of the 38 residents included in the Stage 2 review.

The findings included:

1. Review of the facility's "[named facility] Resident Funds" policy documented, "...Funds are available for withdrawal Monday- [through] Friday from 7am-6pm, (providing that there is enough funds in resident's account) at the front desk..."

2. During an interview in Resident #17's room on 12/12/11 at 4:28 PM, Resident #17 was asked, "Can you get your money when you need it, including on weekends?" Resident #17 stated, "No, can't get it [money] on weekends."

3. During an interview in Resident #23's room on 12/12/11 at 4:08 PM, Resident #23 was asked, "Can you get your money when you need it,
**Continued From page 2**

including on weekends?" Resident #23 stated, "Not sure I can get money on the weekend. I have never tried because the lady that works in there is off on Saturday and Sunday."

4. During an interview in Resident #28's room on 12/12/11 at 3:30 PM, Resident #28 was asked, "Can you get your money when you need it, including on weekends?" Resident #28 stated, "No, can get money anytime except weekend."

5. During an interview in the front office on 12/14/11 at 2:35 PM, the Skilled Bookkeeper was asked if personal funds were available if a resident requested a withdrawal on weekends or evenings. The Skilled Bookkeeper stated, "An employee will give them [the resident] money out of their own pocket. When it is after hours if an employee working here and has the money in their pocket they would loan it to them. After hours there would be no one here to get the money for them, just like a bank. If they tell us in advance we would get the money for them, but we need a notice."

During an interview in the Administrator's (Adm) office on 12/14/11 at 3:32 PM, the Adm was asked if personal funds were available to residents on weekends and evenings. The Adm stated, "I just live about 5 minutes away and [named employee] also lives near. We could run up here if needed. If they let us know ahead of time we could have the funds ready."

The resident has the right, unless adjudged incompetent or otherwise found to be

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**X1 PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:**

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<td>F 280</td>
<td>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</td>
<td>F 280</td>
<td>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</td>
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incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to ensure resident/responsible party were invited to participate in care planning for 2 of 14 (Residents #23 and 36) sampled residents interviewed and 1 of 3 (Resident #94) sampled residents family member interviews of 38 residents included in the stage 2 review.

The findings included:
1. Medical record review for Resident #23 documented an admission date of 6/16/09 with diagnoses of Congestive Heart Failure Exacerbation, Hypertension, Pacemaker, Hyperlipidemia and Myasthenia Gravis. Review of

Requirements:
The facility will ensure resident/responsible party will be invited to participate in care planning for all residents.

Corrective Action:
1. On 12/16/11 Residents/responsible party of #23, #36, and #94 was invited to their care plan meeting.
2. An audit of the facility care plans was conducted starting 12/16/11 and completed on 12/22/11 by the DON, ADON, and MDS Coordinator to ensure they reflect invitations to Care plan meetings.
3. The MDS Coordinators were on 12/16/11 compliance. The MDS Coordinators will document on the Care Plan when the invite a resident/responsible party to a care plan meeting.
4. DON, ADON, MDS Coordinator will do monthly and random audits to monitor for compliance, and will report to our QA&A Committee Quarterly.
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the minimum data set (MDS) with an assessment reference date (ARD) of 5/14/11 section C-Cognition coded the resident with a summary score of 11. Review of the MDS dated 11/17/11 Section C0500-Cognition coded the resident a 10-these scores indicated the resident was moderately impaired in decision-making skills.

Review of the "MDS/Care Plan Progress Notes" dated 5/14/11 through 11/21/11 there was no documentation of the resident being informed of the care plan meeting or of family member being invited to the care plan meeting.

During an interview in Resident #23's room on 12/12/11 at 4:10 PM, Resident #23 was asked if she was involved in decisions about her daily care. Resident #23 stated, "Not sure about that, but don't think so."

The facility was unable to provide documentation of the resident being informed of the care plan meeting or of family member being invited to care plan meeting.

2. Medical record review for Resident #36 documented an admission date of 6/12/09 with diagnoses of Degenerative Joint Disease Lower Leg, Severe Osteoarthritis, Hypertension, Hypothyroidism and Intractable Diarrhea. Review of the MDS with an ARD of 4/25/11 section C0500 coded the resident as 14-indicating cognitively intact and review of the MDS dated 10/20/11 section C0500 coded the resident as 12-indicating moderately impaired in cognition.

Review of the "MDS/Care Plan Progress Notes" dated 1/27/11 through 11/4/11 there was no
F 280 Continued From page 5

documentation of the resident/family member being invited or in attendance at the care plan meeting.

During an interview in Resident #36 room on 12/12/11 at 3:48 PM, Resident #36 was asked if she was involved in decisions about her daily care. Resident #36 stated, "Not sure about that, but don't think so."

The facility was unable to provide documentation of the resident being informed of the care plan meeting or of family member being invited to care plan meeting.

3. Medical record review for Resident #94 documented an admission date of 9/10/10 with diagnoses of Cerebral Vascular Accident - Late Effect, Cardiomegaly, Diabetes Mellitus Hypertension, Coronary Artery Disease, Hyperlipidemia, Respiratory Failure, Gastroesophageal Reflux Disease, and Pneumonia. Review of the MDS with an ARD of 8/29/11 section C-Cognition coded the resident as OS indicating severely impaired in decision-making. Review of the MDS with an ARD of 11/27/11 section C-Cognition coded the resident as OS-indicating severely impaired in decision-making skills. Review of the "MDS/Care Plan Progress Notes" dated 9/10/10 through 11/29/11 there was no documentation of the resident or his spouse being invited to the care plan meetings.

During a telephone interview with Resident #94’s spouse on 12/13/11 at 11:00 AM, Resident #94’s spouse was asked about care plan meetings. Resident #94’s spouse stated, " Haven't been to..."
**continued**

The facility was unable to provide documentation of the resident being informed of the care plan meeting or of family member being invited to care plan meeting.

4. During an interview in the classroom on 12/13/11 at 1:20 PM, the MDS nurse stated, "We send them out letters quarterly to family member and go to room and tell the resident. We don't document that we mailed letter to family member or informed resident of the care plan meeting. If they actually participate in the meeting then we will document it."

**483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN**

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 glasses for 1 of 18 (Resident #29) sampled residents reviewed of 38 residents included in the Stage 2 review.

The findings included:

- Medical record review for Resident #29 documented an admission date of 9/29/11 with...
### F 282: Continued From page 7

**Diagnoses of Osteoporosis, Depression, Chronic Obstructive Pulmonary Disease, Hypertension, Cerebrovascular Accident, and Failure to Thrive.**

Review of the comprehensive care plan dated September 2011 and revised November 2011 documented, "...Place eyeglasses on with AM care, and replace as needed..." Review of the "Nurse's Admission/Readmission Assessment" dated 9/29/11 documented, "...VISION...Wears Glasses: Yes [checked]"

Observations in Resident #29's room on 12/12/2011 at 2:15 PM and on 12/13/11 at 9:10 AM, revealed Resident #29 was not wearing glasses.

Observations and interview in Resident #29's room on 12/14/2011 at 12:45 PM, revealed Resident #29 sitting up in bed eating lunch, not wearing glasses. Resident #29 stated he wanted his glasses on the overbed table, but he didn't know where they [staff] put them. Resident #29 stated, "I need my glasses when my eyes get tired and to read."

During an interview in Resident #29's room on 12/12/2011 at 2:19 PM, Resident #29 was asked if he had any personal items missing. Resident #29 stated, "Yes, I need my glasses. I'm 94 years old and I don't see too good, especially when I want to read."

During an interview at the nurses' station on 12/13/11 3:00 PM, Nurse #4 was asked if Resident #29 wore glasses. Nurse #4 reviewed the care plan and stated, "This [care plan] says he [Resident #29] wears glasses and they are to be put on him every day." Nurse #4 went to

| F 282 | 3. The DON, ADON, MDS Coordinator, and Administrator will audit care plans weekly times 3 weeks and then monthly to ensure care plans are being followed.

| F 282 | 4. The DON, ADON, MDS Coordinator, and Administrator will monitor monthly and do random audits for compliance and report findings to our QA&A Committee Quarterly. |
COVINGTON CARE CENTER

F 282
Continued From page 8

Resident #29’s room and looked in the night stand top drawer and found the resident’s glasses under other items. Nurse #4 stated, “We need to make sure he has his glasses.”

483.25(i) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use, or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:

Based medical record review and interview, it was determined the facility failed to ensure a resident was free from unnecessary medications.

F 329

483.25 (i) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS.

SS=D

Requirements:
Drug regimen is free of unnecessary drugs.

Corrective Actions:

1. 12/14/11 the Medical Director review resident #117 medications and gave a diagnosis for chlorpheniramine maleate.

2. Nurses were in serviced on 12/16/11 to get orders to discontinue unnecessary drugs or get the appropriate diagnosis for medication.

3. On 12/16/11 the DON, ADON, MDS Coordinator, and Administrator audited charts and received orders for diagnosis or discontinue unnecessary drugs. There will be monthly and random audits for compliance.

4. The DON, ADON, MDS Coordinator, and Administrator will do weekly audits time 3 weeks and random and monthly audits will be done to ensure we are in compliance.
**F 329** Continued From page 9  
for 1 of 10 (Resident #117) sampled residents of the 38 residents included in the Stage 2 review.

The findings included:

Medical record review for Resident #117 documented an admission date of 11/11/11 with diagnoses of Chronic Obstructive Pulmonary Disease, Right Wrist Fracture, Cardiac Ischemia, and Urinary Tract Infection. Review of a physician's order dated 11/23/11 documented "...Give chlorpheniramine maleate 1 po [by mouth] BID [twice a day]..."

During an interview at the nurse's station on 12/14/11 at 8:39 AM, Nurse #5 was asked about the diagnosis for the use of the Chlorpheniramine Maleate for Resident #117. Nurse #5 stated, "I don't see a diagnosis... there is not a diagnosis for the Allegra [Chlorpheniramine Maleate]."

During an interview in the Director of Nursing's (DON) office on 12/14/11 3:45 PM, the DON was asked about the diagnosis for the use of the Chlorpheniramine Maleate. The DON stated, "The pharmacist had no recommendations. He focuses on one area each month but still should have reconciled the diagnoses."

**F 332**  
483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  
The facility must ensure that it is free of medication error rates of five percent or greater.

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

**483.25 (m)(1) FREE OF MEDICATION ERROR RATE OF 5% OR MORE.**  
SS=D  
12/16/11  
Requirements:  
The facility must ensure that it is free of medication error rates of five percent or greater.
F 332: Continued From page 10

Based on review of the "Mosby's Nursing Drug Reference", review of the "Medication Guide for the Long-Term Care Nurse", policy review, medical record review, observations and interviews, it was determined the facility failed to ensure 3 of 5 (Nurses #1, 2 and 3) nurses administered medications with a medication error rate less than five percent (%). There were 4 medication errors out of 52 opportunities for error, which resulted in a medication error rate of 7.6%.

The findings included:


2. Review of the "Medication Guide for the Long-Term Care Nurse", tenth edition, page 60 documented, "...If additional drops of the same or different medication are required in the same eye, wait 3-10 minutes..."

Medical record review for Resident #16 documented an admission date of 7/22/10 with diagnoses of Diabetes Mellitus, Hypertension, Vascular Dementia and Cerebrovascular Accident. Review of a physician's order dated 10/28/11 documented, "...GENTEALE PRESV [preservative] FREE OPHTH [ophthalmic] DROPS TWO DROPS BOTH EYES TWO TIMES DAILY..."

Observations in Resident #16's room on 12/13/11 at 8:03 AM, Nurse #1 administered Gentecal Eye drops (gtts) two drops to both of Resident #16's

F 332

Corrective Actions:

1. On 12/16/11 the ADON observed
   Nurse #1 administer eye drops to resident #16 and the nurse waited the 3 minutes between drops. The ADON watched Nurse #1 give Tylenol to resident #59, and the nurse gave the correct dosage. Nurse #2 was observed giving resident #10 their Coreg 6.25 mg po, and the nurse did check the pulse before administering medication. Nurse #3 was observed flushing resident #25's INT and the nurse did flush with eth correct amount of N.S.

2. The nursing staff was in-serviced on 12/15/11 on the correct procedures of administering medications.

3. On 12/16/11 DON and ADON, conducted a random med pass audit to ensure licensed staff were in compliance with administration of medication. The DON and ADON will do monthly and random audits for compliance.

4. The DON and ADON or designee will do monthly audits of med pass and will report findings to the QA&A team quarterly.
F 332 Continued From page 11

eyes. Nurse #1 did not wait at least 3 minutes between administration of the eye gtt. Failure to wait at least 3 minutes between eye gtt resulted in medication error #1.

3. Medical record review for Resident #59 documented an admission date of 12/23/06 with diagnoses of Rhabdomyolysis and Diabetes Mellitus. Review of the physician's standing orders dated 9/15/11 documented, "...Tylenol 325 mg [milligram] - 650 mg, po or per PEG [Percutaneous Endoscopy Gastrostomy] tube or suppository p.r. [per rectum] every 4 hours PRN [as needed] for headache, pain..."

Observations in Resident #59's room on 12/14/11 at 9:50 AM, Nurse #1 administered two tablets of Tylenol 500 mgs to Resident #59. The administration of the two tablets of Tylenol 500 mgs resulted in medication error #2.

During an interview at the nurse's station on 12/14/11 at 2:55 PM, Nurse #1 confirmed there was no physician's order for the Tylenol 500 mg.

4. Review of the "Mosby's Nursing Drug Reference", twenty-second edition, pages 235 through (-) 236, documented, "...Coreg... apical-radial pulse before administration..."

Medical record review for Resident #10 documented an admission date of 8/17/09 with diagnoses of Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. Review of a physician's order dated 12/9/11 documented, "...Coreg 6.25 mg Po [by mouth] 1 TID [three times a day]..."
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/Clien Identification Number:** 445330  
**Multiple Construction:**  
A. Building  
B. Wing  
**Date Survey Completed:** 12/15/2011

**Name of Provider or Supplier:** Covington Care Center  
**Street Address, City, State, Zip Code:** 765 Bert Johnston Ave P O Box 544, Covington, TN 38019

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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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Observations in Resident #10's room on 12/12/11 at 4:38 PM, Nurse #2 administered Coreg 6.25 mg to Resident #10. Nurse #2 did not check Resident #10's pulse prior to administering the Coreg. The failure to check the pulse rate before administering the Coreg resulted in medication error #3.  
Observations in Resident #25's room on 12/14/11 at 2:29 PM, revealed Nurse #3 flushed the INT with 2 cubic centimeters (cc's) of normal saline. The failure to flush the INT with 3 cc's of normal saline resulted in medication error #4.  
During an interview at the nurse's station on 12/14/11 at 2:50 PM, Nurse #3 was asked how much normal saline she flushed the INT with. Nurse #3 stated, "2 cc's." | F 332  
483.60(c) Drug Regimen Review, Report Irregular, Act On  
The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  
The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. | 12/15/11 |
This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review and interview, it was determined there was a lack of pharmacy review for 1 of 10 (Resident #117) sampled residents of 39 residents included in Stage 2. There was no documentation in the pharmacist's medication reviews that the pharmacist had reported to the physician or the Director of Nursing (DON) that there was no indication of the use of Chlorpheniramine Maleate documented.

The findings included:

Review of the facility's "Consultant Pharmacist" policy documented, "...As a part of the drug regimen review the consultant will review diagnosis..."

Medical record review for Resident #117 documented an admission date of 11/11/11 with diagnoses of Chronic Obstructive Pulmonary Disease, Right Wrist Fracture, Cardiac Ischemia, and Urinary Tract Infection. Review of a physician's order dated 11/23/11 documented "...Give chlorpheniramine maleate 1 po [by mouth] BID [twice a day]."

During an interview at the nurse's station on 12/14/11 at 8:39 AM, Nurse #5 was asked about the diagnosis for the use of the Chlorpheniramine Maleate for Resident #117. Nurse #5 stated, "I
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| F 428 | Continued From page 14  

"I don't see a diagnosis... there is not a diagnosis for the Allegra [Chlorpheniramine Maleate]."

During an interview in the Director of Nursing's (DON) office on 12/14/11 3:45 PM, the DON was asked about the diagnosis for the use of the Chlorpheniramine Maleate and if the Pharmacist had made any recommendations. The DON stated, "The pharmacist had no recommendations. He focuses on one area each month but still should have reconciled the diagnoses."

F 441 | 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  
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...
F 441  Continued From page 15
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 the facility failed to
ensure practices to prevent the spread of
infection were maintained when 1 of 2 (Nurse #2)
nurses observed performing accucheck failed to
wear gloves when performing the accucheck.

The findings included:

Review of the facility's "RECOMMENDED
INFECTION-CONTROL SAFE INJECTION
PRACTICES TO PREVENT PATIENT- TO-
PATIENT TRANSMISSION OF BLOODBORNE
PATHOGENS" policy documented, "...Wear
gloves during fingerstick glucose monitoring and
during any procedure that involves potential
exposure to blood or body fluids..."

Observations in Resident #10's room on 12/12/11
at 4:45 PM, Nurse #2 performed a fingerstick
glucose check on Resident #10. Nurse #2 did not
wear gloves to perform the fingerstick glucose

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| 441 | F  | 441 | 3. | On 12/12/11 licensed staff was
in-serviced on infection control,
wearing gloves to prevent
patient to patient, or patient to
staff transmission of blood borne
pathogens.

4. The DON and ADON will do
weekly monitoring times 3
weeks then monthly to check for
compliance of infection control
procedures.
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During an interview on the 100 hall on 12/14/11 at 4:32 PM, Nurse #2 was asked why she didn't wear gloves when performing the accucheck. Nurse #2 stated, "I totally forgot."