### F 164

**SS=D 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS**

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident’s right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident’s records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payers; or the resident.

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

- Based on medical record review, observation, review of facility policy, and interview, the facility failed to maintain privacy during a medical treatment for one resident (#102) of twenty-seven residents reviewed.

### F 164

- This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Willow Ridge Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.

1. Nurse Practice educator or designee began re-education on providing privacy during medical treatments on November 14, 2013 with staff.
2. On November 26, 2013 an audit was conducted by the Director of Nursing or designee to identify residents with tube feedings. Those residents with tube feedings were reviewed and no other privacy issues were identified.
3. The Nurse Practice Educator or Nursing Management designee will re-educate staff by December 6, 2013 on maintaining privacy during medical treatments.
4. Nursing Management or designee will complete an audit of residents with tube feedings for one month and monthly for 3 months and as recommended by the...
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The findings included:

- Resident #102 was admitted to the facility on July 12, 2013, with diagnoses including Specific Rehabilitation Procedures related to Motor Vehicle Accident, Psychotic Disorder, Muscle Weakness, and Dysphagia.

- Observation on November 14, 2013, at 10:00 a.m., in the lobby, revealed resident #102 sitting in a recliner with a pillow positioned between the legs and tube feeding hanging from a pole with a tube running under the shirt. Further observation revealed no blanket on the resident. Next to the resident, the Administrator was talking to a visitor. Further observation revealed the Nursing Supervisor lifted the resident’s shirt, exposed the abdominal PEG (Percutaneous Endoscopic Gastrostomy - a tube placed in the abdomen to administer feedings through) insertion site, and replaced the valve on the tube feeding.

- Review of the facility policy Treatment: Considerate and Respectful, revised on September 1, 2013, revealed, "...assist the patient to maintain and enhance his/her self-esteem and self-worth...maintain patient privacy of body including keeping patients sufficiently covered..."

- Interview with the Nursing Supervisor on November 14, 2013, at 10:10 a.m., in the nursing station, confirmed the nurse did not maintain the privacy of the resident.

- Interview on November 14, 2013, at 10:14 a.m., in the nursing station, with the Director of Nursing, confirmed the facility policy was not followed to maintain the resident’s privacy.
## F 441 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 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.

### F 441

1. Nurse Practice educator or designee began re-education on proper hand hygiene on November 12, 2013 with staff passing food service trays.
2. Residents receiving meal trays have the potential to be affected. An audit was conducted on November 26, 2013 by the Director of Nursing to identify proper hand hygiene while passing trays, no other hand hygiene issues were identified.
3. The Nurse Practice Educator or designee re-educated staff on proper hand hygiene while passing trays beginning on November 12, 2013 and will be completed by December 6, 2013.
4. The Director of Nursing or designee will observe meal tray delivery 2 times weekly for 4 weeks and 1 times weekly for two months. The Administrator or designee will review and analyze the results of audits for infection control during the monthly Performance Improvement Committee for three months to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary.

12/06/2013
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
WILLOW RIDGE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
215 RICHARDSON WAY
MAYNARDVILLE, TN 37807

**DATE OF SURVEY COMPLETED**
11/14/2013

<table>
<thead>
<tr>
<th>F 441</th>
<th>Continued From page 3</th>
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<tbody>
<tr>
<td>This <strong>REQUIREMENT</strong> is not met as evidenced by:</td>
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<tr>
<td>Based on observation, review of facility policy, and interview, the facility failed to perform hand hygiene during dining for twenty of twenty-five residents observed in the dining room and for three of three residents observed on one (West) of two halls.</td>
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The findings included:

Observation on November 12, 2013, at 11:30 a.m., in the dining room, revealed Certified Nursing Assistant (CNA) #1, CNA #2, and CNA #3, handing out lunch trays, touching the resident's trays, and touching the residents without wearing gloves or washing hands between touching the residents and touching the food trays. Continued observation revealed this occurred for twenty of twenty-five residents observed.

Review of facility policy, Hand Hygiene, last revised March 1, 2008, revealed:
"...decontaminate hands...alcohol based hand rub...or wash hands with antimicrobial soap...before direct contact with patient...contact with object...vicinity of the patient..."

Interview with the Regional Nurse, on November 12, 2013, at 11:30 a.m., in the hallway outside the main dining room, confirmed hands must be washed prior to touching a resident's food or food tray, and when contact had occurred with the resident. Continued interview with Regional Nurse confirmed the policy had not been followed.

Observation on November 11, 2013, at 11:45
**F 441**: Continued From page 4

a.m., in the west hall, revealed CNA #4, entered a resident's room with a lunch tray, cut up the resident's food, and exited the room without washing the hands. Further observation revealed CNA #4 returned twice to the meal cart, removed a resident's lunch tray, entered the room, cut up the food for the next resident, and exited without washing the hands.

Interview with CNA #4 on November 11, 2013, at 11:50 a.m., in the west hall, confirmed the CNA failed to wash the hands between resident contact.

Interview on November 14, 2013, at 10:55 a.m., with the Infection Control Nurse, in the Infection Control office, confirmed the hand hygiene policy had not been followed.