F 000  INITIAL COMMENTS

Complaint investigation for complaint numbers TN00031098, TN00031262 and TN00031528 was conducted from 4/22/13 to 4/24/13.

F 322 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Licensed nursing staff responsible for residents #5 and #7 were educated on the following of physician orders and tube feeding via PEG, to include the documentation of time off of feeding. Education was provided by the Director of Nursing Services on 4/29/13.

Medication orders for resident #7 instruct that the medications be given via PEG tube. Orders were received on 4/23/13. Care plan was updated with instructions to reflect PEG site care. Also reflected in ADL care-guide.

Director of Nursing Services and the Assistant Director of Nursing Services will provide education via in-service to all licensed and certified nursing staff concerning the following of physician orders for the administration of tube feeding and medication administration via PEG tube and PEG site care.

2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

Any resident receiving feeding or medication via PEG can potentially be affected by the alleged deficient practice.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

FORM CMS-2587(02-99) Previous Versions Obsolete  Event ID: DEUQ11  Facility ID: TN0301  If continuation sheet Page 1 of 17
**F 322** Continued From page 1
and #7) sampled residents with PEG tubes.

The findings included:

1. Medical record review for Resident #5 documented an admission date of 11/23/12 with diagnoses of Encephalopathy, Clostridium Difficile, Anxiety, Depression, Hyperlipidemia, Hypertension, Dysphagia, Peptic Ulcer, Diabetes Mellitus Type II, Pneumonitis, Cerebral Vascular Accident, Anemia, PEG and Herpes Zoster. Review of a physician order dated 2/21/13 documented an order for "Glucerna 1.0 @ [at] 85 ml [milliliters] / [per] hr [hour] x [times] 22 hours per day to provide 1870 ml Glucerna/day. Do not schedule time off, turn off as needed for therapy and ADLS [activities of daily living]." Review of Progress Notes dated 4/15/13 at 1:03 PM and 4/20/13 at 3:12 PM documented, "Receiving Glucerna 1.0 infusing at 85 ml/hr, off for several hours during the day, respectively." Review of Progress Note dated 4/22/2013 at 7:00 PM revealed no documentation of the feeding infusing.

   Observation in Resident #5's room on 4/22/13 at 1:52 PM and 3:38 PM, revealed Resident #5 in a wheelchair disconnected from the PEG tube feeding.

   Observation in Resident #5's room on 4/22/13 at 4:15 PM and 4:46 PM, revealed Resident #5 in bed disconnected from the PEG tube feeding.

During an interview at the 200 hall nurse's station on 4/24/13 at 10:53 AM, Nurse #2 was asked what the tube feeding order for Resident #5 was on 4/22/13. Nurse #2 stated, "The order was for PEG tube orders will be audited weekly for a total of 1 month until 100% compliance is reached. Once 100% compliance is reached then orders will be audited bi-weekly for two months. Orders will also be reviewed daily during Clinical Start Up meeting, a meeting made up of the Director of Nursing, Assistant Director of Nursing, Director of Clinical Education, Wound Care Coordinator, MDS Coord, Social Services Director, Activity Director and Transitional Care Director.

4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place?

Results from the audits will be presented to the Quality Assurance team monthly. The Quality Assurance team includes: Executive Director, Director of Nursing Services, Assistant Director of Nursing Services, Food Services Director, Medical Director, Environmental Services Director, Maintenance Director, MDS Coordinator, Social Services, Activities Director, Rehab Services Manager and Transitional Care Unit Director. The QA process will assist the facility in identifying trends, implementing a plan and identifying a responsible person to follow through and will be able to continue monitoring until resolved.
F 322  Continued From page 2

Glucerna at 85 cc [cubic centimeters] per hour and we disconnect it for several hours when she is up or out of the room and we reconnect her when she gets back to bed." Nurse #2 was asked how do you track and document the hours that the resident is disconnected from the feeding. Nurse #2 stated "It is very difficult to track."

2. Review of the facility's "Medication Administration General Guidelines" policy documented, "...f. Medications are administered in accordance with written orders of the prescriber... 5b. Long-acting, extended release or enteric-coated dosage forms should generally not be crushed; an alternative should be sought..."

Medical record review for Resident #7 documented an admission date of 10/6/12 with diagnoses of Altered Mental Status, Acute Renal Failure, Rhabdomyolysis, Hyperkalemia, PEG, Hydronephrosis, Abdominal Pain, Anxiety, Methicillin Resistant Staphylococcus Aureus Septicemia, Dysthmic Disorder, Insomnia, Depression, Cognitive Deficits, Cerebral Vascular Disease, Dementia, Prostatic Hypertrophy, Dysphagia, Wound and Difficulty Walking. Review of the physician's orders dated 4/1/13 documented, "Citalopram Hydrobromide... 10 mg [milligrams] Tablet By mouth... Haloperidol... 0.5 mg Tablet By mouth... Aspirin... 81 mg Tablet By mouth... TramADol HCL [Hydrochloride]... 50 mg Tablet By mouth - PRN [as needed]... Phos-NaK (280-160-250 MG)... 1 Packet By mouth... Protonix... 40 mg Tablet Delayed Release By mouth..."

During an interview in the 500 hallway on 4/23/13 at 1:45 PM, Nurse #4 was asked how Resident
F 322  Continued From page 3

"#7's medications were administered. Nurse #4 stated, "Through the PEG tube."

The facility failed to administer the medications per mouth as ordered by the physician.

Review of the facility's "Enteral Feeding Tube, Care of" policy documented, "BASIC RESPONSIBILITY Licensed Nurse..."

Review of the care plan dated 11/18/12 documented under the care plan focus of "Dependent on tube feeding... due to: refusals to eat. Documented interventions included...", "Observe and report skin irritation at the tube site..." There was no documented intervention of PEG site care on the care plan.

During an interview in the 500 hallway between room 502 and room 504 on 4/23/13 at 1:45 PM, Nurse #4 was asked about Resident #7's PEG site care. Nurse #4 stated, "He doesn't have an order for site care."

During an interview in the conference room on 4/24/13 at 8:15 AM, when asked about PEG site care, the Director of Nursing (DON) stated, "Our policy is to clean with warm soap and water every shift..."

The facility failed to provide care to the PEG tube site for Resident #7.

F 328  483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  

The facility must ensure that residents receive proper treatment and care for the following special services:
<table>
<thead>
<tr>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 328</td>
<td>Continued From page 4</td>
<td></td>
<td></td>
<td></td>
<td>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</td>
</tr>
<tr>
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<td></td>
<td>Residents #5 and #7 were seen by the podiatrist on 05/06/13.</td>
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<td>2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</td>
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<td></td>
<td>Any resident requiring the services of a podiatrist are at risk of being affected by the alleged deficient practice.</td>
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<td></td>
<td>3) What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?</td>
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<td></td>
<td></td>
<td>Weekly skin assessments and quarterly foot screens are conducted. The assessments and screens will be audited weekly x 1 month; biweekly x 3 months; then monthly x 3 months.</td>
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<td>All nursing staff will be in-serviced on the process for referring a resident for podiatrist services. The in-service will be conducted by the Director of Nursing Services and the Social Services Director.</td>
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<td></td>
<td>Review of the &quot;ON-SIGHT Senior Care&quot; podiatry referral list dated 5/6/13 revealed Resident #5 was listed for a scheduled podiatry visit.</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 ensure residents received podiatry services for 2 of 7 (Residents #5 and #7) sampled residents.

The findings included:

1. Medical record review for Resident #5 documented an admission date of 11/23/12 and a readmission date of 1/21/13 with diagnoses of Hypertension, Cerebral Vascular Accident (CVA) with Left Side Hemiplegia, Diabetic Mellitus with Neuropathy, Nephropathy, Retinopathy, Depression, Herpes Zoster, Peptic Ulcer Disease (PUD), Chronic Renal Insufficiency, and Cholecystectomy. Review of the "Clinical Health Status Admission" dated 1/21/13 documented in "Section B: Diabetes Foot Screen" a response of "yes" to the following questions: "Are the toenails long, thick, or ingrown?" and "Is there heavy callous build-up?"

Review of the "ON-SIGHT Senior Care" podiatry referral list dated 5/6/13 revealed Resident #5 was listed for a scheduled podiatry visit.
**F 328** Continued From page 5

Observations in Resident #5's room on 4/23/13 at 7:15 AM, revealed Resident #5's right (R) foot was uncovered with toenails of the 1st, 2nd, 3rd and 4th digits were noted to be dark in color, long and thick. The nails were curling past the distal tip of the toes. The 5th digit nail was black in color.

Observation in Resident #5's room on 4/23/13 at 7:50 AM, Nurse #3 removed the sock from Resident #5's right foot and stated "Oh, you have a black nail."

During an interview in Resident #5's room on 4/23/13 at 7:50 AM, Nurse #3 was asked if Resident #5 had seen a podiatrist. Nurse #3 stated, "She [Resident #5] is on the list with social services to see a podiatrist." Nurse #3 was asked what the process was for a podiatrist referral. Nurse #3 stated, "The nurse call the social worker and have them add the resident to the podiatry list."

During an interview in the social services office on 4/24/13 at 7:50 AM, the social worker (SW) stated that certified nursing assistants (CNAs) and nurses give her the names of those who need to be seen by the podiatrist and she puts them on the list. The SW faxes the list to the podiatrist. The SW further stated, "The Podiatrist up and quit last year and we haven't had one since around August [2012]. Suppose to have a new podiatrist May 5th." The SW also stated that CNAs cut the nails if not being seen by the podiatrist. If the podiatrist takes someone off the list the CNA continues the nail care. "We have residents needing toes done. Podiatrist comes every three months."

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**F 328** Cont. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place?

Results from the audits will be presented to the Quality Assurance team monthly. The Quality Assurance team includes: Executive Director, Director of Nursing Services, Assistant Director of Nursing Services, Food Services Director, Medical Director, Environmental Services Director, Maintenance Director, MDS Coordinator, Social Services, Activities Director, Rehab Services Manager and Transitional Care Unit Director. The QA process will assist the facility in identifying trends, implementing a plan and identifying a responsible person to follow through and will be able to continue monitoring until resolved.
F 328 Continued From page 6

2. Medical record review for Resident #7 documented an admission date of 10/6/12 with diagnoses of Altered Mental Status, Acute Renal Failure, Rhabdomyolysis, Hyperkalemia, Anxiety, Percutaneous Endoscopic Gastrostomy (PEG) tube, Hydronephrosis, Methicillin Resistant Staphylococcus Aureus Septicemia, Abdominal Pain, Depression, Cerebral Vascular Disease, Dementia, Prostatic Hypertrophy, and Dysphagia. Review of the Clinical Health Status Admission Assessment for Resident #7 dated 12/18/12 documented in Section B “Nails: K. Thick [circled], L. Discolored [circled], M. Long [circled]... Are the toenails long, thick or ingrown? Right... Y [checked], LEFT... Y [checked]...”

Observations in Resident #7’s room on 4/24/13 at 7:50 AM, revealed the left foot had 5 thick, gray, long toenails and the right foot had 5 thick, gray, medium length toenails.

During an interview in Resident #7’s room on 4/24/13 at 7:50 AM, CNA #2 was asked who would cut the resident’s toenails. CNA #2 stated, “We would cut them, but if they are thick like this, the foot doctor comes in to cut them [toenails].”

F 332 463.25(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:
Based on policy review, medical record review,
F 332 | Continued From page 7  
observation, and interview, it was determined the  
facility failed to ensure the medication error rate  
was less than five percent (%). One (1) of three  
(3) medication nurses (Nurse #3) observed  
administering medications made 4 errors out of  
26 opportunities for error, which resulted in a  
medication error rate of 15.384%.  

The findings included:  

1. Medical record review for Resident #5  
documented an admission date of 11/23/12 with  
diagnoses of Encephalopathy, Clostridium  
Difficile, Anxiety, Depression, Hyperlipidemia,  
Hypertension, Dysphagia, Peptic Ulcer, Anemia,  
Pneumonitis, Diabetes Mellitus Type II, Cerebral  
Vascular Accident and Herpes Zoster. Review of  
the physician's orders dated 1/21/13 documented  "...Ferrous Sulfate 325 mg [milligram] Tablet  
Enteral Tube..."  

Observations in Resident #5's room on 4/23/13 at  
8:15 AM, Nurse #3 administered Ferrous Sulfate  
325 mg through the Percutaneous Gastrostomy  
Tube (PEG) but failed to rinse the medication cup  
leaving multiple particles of the medication in the  
cup. Nurse #3 was asked what the particles in the  
cup were as she was stacking the cups to discard  
them in the trash. Nurse #3 stated, the particles  
"were the iron".  

During an interview in the conference room on  
4/24/13 at 9:43 AM, the Director of Nursing  
(DON) was asked what would be expected of  
nurses regarding medications left in the cup when  
administering medications per PEG. The DON  
stated, "Can I think about this?"  

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| F 332 | 1) What corrective action(s) will be  
accomplished for those residents found  
to have been affected by the deficient  
practice?  

Nurses responsible for care of resident  
#5 were instructed by the Director of  
Nursing Services, on 04/23/13, to use  
5cc of water to rinse remaining particles  
of medication during med administration  
via PEG tube. On 05/07/13, order was  
given to switch Ferrous Sulfate 325mg  
to liquid. This will ensure resident is  
receiving entire dose as ordered.  

On 04/23/13, nurses responsible for the  
care of resident #4 were educated by the  
Director of Nursing Services on the  
following of orders for medication  
administration. Order was changed on  
04/23/13 for medication to be given  
PO or PEG tube as resident desires.  

2) How will you identify other residents  
having the potential to be affected by the  
same deficient practice and what corrective  
action will be taken?  

Any resident receiving medications via  
PEG tube are at risk of being affected  
by the alleged deficient practice.
<table>
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<th>F 332</th>
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<tbody>
<tr>
<td>The failure to administer the complete dose of Ferrous Sulfate as ordered resulted in medication error #1.</td>
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</table>

2. Review of the facility's medication administration policy documented, "...POLICY Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices..." 

Medical record review for Resident #4 documented an admission date of 4/2/13 with diagnoses of Pyoderma Gangrenosum, Essential Hyperension, Hyperlipidemia, Anxiety Disorder, Depressive Disorder, Anemia, Chronic Obstructive Pulmonary Disease, Left Above Knee Amputation, Severe Protein Calorie Malnutrition, Peripheral Vascular Disease, Condyloma Acuminatum, Diabetes Mellitus Type II, Osteomyelitis and Atherosclerosis. Review of the physician's order dated April 2013 documented, "...CeleXA ... (Citalopram Hydrobromide) 40 MG [milligram] Tablet By mouth... Ascorbic Acid... 500 MG Tablet By mouth... Multi-Minerals [Multiple Minerals] Tablet By mouth..."

Observations in Resident #4's room on 4/23/13 at 9:20 AM, Nurse #3 administered Celexa 40 mg, Multivitamin with Minerals 1 tablet, and Ascorbic Acid 500 mg through the PEG tube.

During interview in the 200 hall nurse's station on 4/23/13 at 2:30 PM, Nurse #3 stated, "...There should be an order that she [Resident #4] could take them either way." 

The administration of Celexa 40 mg, Multivitamin with Minerals 1 tablet, and Ascorbic Acid 500 mg...
F 332
Continued From page 9
tablet through the PEG tube instead of by mouth
resulted in medication errors #2, 3, and 4.

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
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
This REQUIREMENT is not met as evidenced by: Based on review of the occupational safety and health administration (OSHA) Handbook: The Guidelines for compliance in health care facilities, policy review, medical record review, observation, and interview, it was determined the facility failed to prevent the potential spread of infection when 3 of 3 nurses (Nurses #1, 2, and 3) failed to use hand hygiene, carried an uncapped needle into a resident room during the administration of medications, failed to clean the Percutaneous Gastrostomy Tube (PEG) site in a circular motion and/or failed to maintain a clean field for the PEG tube during medication administration.

The findings included:

1. Review of the infection control policy presented by the corporate nurse consultant documented, "F 441 483.65 - Infection Control... 483.65 (b) Preventing Spread of Infection... (3) The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice... Hand Hygiene... Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice)... Before and after changing a dressing... After contact with a resident's mucous membranes and body fluids or excretions... After handling soiled or used linens, dressings... After removing gloves... gloves or the use of baby wipes are not a substitute for hand hygiene..."
F 441 Continued From page 11

During an interview in the conference room on 4/24/13 at 9:43 AM, the corporate nurse consultant was asked if the policy presented was the facility infection control policy or the regulation from Appendix PP. The corporate nurse consultant stated, "This came out of our infection control manual."

2. Review of "The OSHA Handbook: The Guidelines for Compliance in Health Care Facilities" documented, "Chapter 8 Methods of Compliance... page 90 General information... 4. Recapping is permitted on clean needles when needles are to be changed or when drawing up medication..."

Review of the facility's medication administration policy documented, "...SUBCUTANEOUS... PROCEDURES... Withdraw correct amount of medication... Create air lock in syringe by pulling a small amount of air into the syringe... Recap needle using appropriate safety device..."

Observations in Random Resident (RR) #1's room on 4/22/13 at 11:47 AM, Nurse #1 aspirated 10 units of Novolog Insulin into a syringe at the medication cart outside RR #1's room and walked with the needle uncapped into RR #1's room.

During an interview in the conference room on 4/24/13 at 9:43 AM, the corporate nurse consultant was asked what would be expected of a nurse taking an injection into the room after drawing up the medication. The corporate nurse consultant stated, "Would expect them [nurses] to walk with the needle down... Never recap needles. Against OSHA..."

4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place?

Findings from the random audits will be reported to the QA Committee during the monthly QA meeting. Those in attendance at the QA meetings include:
Executive Director, Director of Nursing Services, Assistant Director of Nursing Services, Food Services Director, Medical Director, Environmental Services Director, Maintenance Director, MDS Coordinator, Social Services, Activities Director, Rehab Services Manager and Transitional Care Unit Director. The QA process will assist the facility in identifying trends, implementing a plan and identifying a responsible person to follow through and will be able to continue monitoring until resolved.
During an interview at the main nurses’ station on 4/24/13 at 11:30 AM, Nurse #1 stated, “I would either slide it up or scoop the cap. More likely would slide it up. I was nervous.”

3. Review of the facility’s medication administration policy documented, "...ENTERAL TUBE MEDICATION ADMINISTRATION PROCEDURES PURPOSE To safely and accurately administer oral medication through an enteral tube... 3. Wash hands per facility policy. 4. Verify tube placement... 11. Clean feeding syringe and return to bedside stand... 13. Wash hands per facility policy..."

Medical record review for Resident #5 documented an admission date of 11/23/12 with diagnoses of Encephalopathy, Clostridium Difficile, Anxiety, Depression, Hyperlipidemia, Hypertension, Dysphagia, Peptic Ulcer, Diabetes Mellitus Type II, Pneumonitis, Cerebral Vascular Accident, Anemia, Percutaneous Endoscopic Gastrostomy (PEG), and Herpes Zoster.

Observations during medication administration in Resident #5’s room on 4/22/13 at 1:55 PM, Nurse #2 donned gloves, closed the door to the hallway, pulled the privacy curtain, removed her glasses from the top of her head, placed the syringe in the tip of the PEG tube, poured 150 cubic centimeters (cc) of water into the pitcher, pushed the glasses back up on the top of her head, placed the stethoscope on the resident’s abdomen, injected air to check for placement, removed her glasses and placed them on the resident’s bed, and poured water into the syringe to flush the tube. Nurse #2 then poured water in
<table>
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<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<td>F 441</td>
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the medicine cup with the medication and stirred the medication with her gloved finger, flushed the tube with the remaining water, and plugged the tube.

During an interview in the 200 hall nurse's station on 4/24/13 at 7:30 AM, Nurse #2 was asked about the handling of patient care equipment and contaminated surfaces without washing hands prior to administering medications through the PEG. Nurse #2 stated, "You're right."

4. Observations during medication administration in Resident #5's room on 4/23/12 at 8:15 AM, Nurse #3 donned gloves, pulled the privacy curtain around the end of the bed, filled the pitcher with 150 cc of water, placed the stethoscope on the resident's abdomen, injected air in the PEG tube to check for placement, and poured water into each cup of medication. Nurse #3 removed her gloves, went to the medication cart outside the room, returned to the room, donned gloves, disconnected the PEG tube from the pump, and flushed the PEG tube with 30 cc of water. Nurse #3 was unable to get the water to flow into the tube, milked the PEG tube with the gloved hand, dropped the tip of the PEG tube on the bed covers, removed her gloves, donned gloves, reconnected the PEG tube, flushed the tube with the remaining water, and reconnected the PEG tube to the tubing on the pump. Nurse #3 then removed the gloves and donned clean gloves. Nurse #3 then went to the sink to saturate the 4 by (x) 4's with warm water and soap. Nurse #3 began cleaning the PEG tube site under the PEG tube starting at the bottom of the tube, wiping up to the tube insertion site, and around to the top of the insertion site cleaning the top in the
F 441  Continued From page 14

same manner as the underside of the tube, and

Forest #3 did not rotate the sides of the 4x4
during the cleaning process and then placed
soiled 4x4's on the clean 4x4's that were used to
dry the site. The PEG tube came disconnected
with formula flowing onto the bed covers. Nurse
#3 reconnected the tube and rolled the covers up.
Nurse #3 then removed the gloves and washed
her hands.

During an interview in the conference room on
4/24/13 at 8:15 AM, the Director of Nursing
(DON) was asked about the policy regarding
cleaning the PEG site. The DON stated, "Our
policy is to clean inside out."

5. Review of the facility's medication
administration policy documented,
"...Transdermal Delivery Systems (Patches)...
Perform hand hygiene. 4. Put on gloves... 10.
Apply new patch... 11. Remove gloves. 12.
Perform hand hygiene..."

Medical record review for Resident #4
documented an admission date of 4/2/13 with
diagnoses of Pyoderma Gangrenosum, Essential
Hypertension, Hyperlipidemia, Anxiety Disorder,
Anemia, Depressive Disorder, Chronic
Obstructive Pulmonary Disease, Left Above Knee
Amputation, Severe Protein Calorie Malnutrition,
Peripheral Vascular Disease, Condyloma
Acuminatum, Diabetes Mellitus Type II,
Osteomyelitis, Atherosclerosis and Percutaneous
Endoscopy Gastrostomy (PEG) Tube. Review of
the physician's order dated April 2013
documented "...FentaNYL... 50 MCG
[micrograms] / [per] HR [hour] Patch 72 Hour
F 441  Continued From page 15

Transdermal - once daily...

Observations during medication administration in Resident #4's room on 4/23/12 at 9:20 AM, Nurse #3 donned gloves, administered medications by mouth applied the Fentanyl Patch, and then removed the gloves. Nurse #3 then donned clean gloves. She then disconnected the PEG tube, connected the syringe to the PEG tube, placed stethoscope onto chest, checked placement, removed stethoscope and replaced around her neck. Nurse #3 went to the sink and filled the graduate pitcher with 150 cc of water, flushed the PEG tube with 20 cc water, administered each medication through the PEG tube and flushed the PEG tube with 10cc water between medications. Nurse #3 rinsed the syringe and replaced it in the plastic bag hanging on the PEG tube pole. Nurse #3 then removed the gloves and donned clean gloves. Nurse #3 proceeded to provide PEG tube site care. Nurse #3 removed the soiled dressing, cleaned around the PEG site with the 4x4 saturated with soap, starting at the bottom of the tube, wiping up to the tube insertion site, and around to the top of the insertion site cleaning the top in the same manner as the underside of the tube, and going from cleaned area to dirty area repeatedly. Nurse #3 then rinsed the PEG tube site with the 4x4's saturated with water. She did not rotate the sides of the 4x4 during the cleaning process or rinsing process and each time placed the soiled 4x4 on the clean 4x4's in her hand that were used to dry the site. The PEG site appeared very red. Nurse #3 stated, "Think you need some antibiotics for it. Think I will call [named nurse practitioner]. Looks like a little infection going on."

6. During an interview in the conference room
F 441  Continued From page 16

on 4/24/13 at 9:43 AM the DON was asked when she would expect the nurses to perform hand hygiene. The DON stated, "When the gloves are removed would expect to wash hands."