

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/26/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345374	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/12/2011
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NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE / NASHVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1022 EASTERN AVENUE NASHVILLE, NC 27856
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F 253 SS=D	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to ensure that resident 's personal care equipment was labeled and properly stored for 2 of 3 halls. The findings include:</p> <p>1. On 10/11/11 at 10:21 AM an observation of the bathroom shared by the 4 residents in rooms 111 and 113 revealed 2 racks over the toilet. There were 2 bath basins on the top right shelf stacked in one another. The top basin was labeled with the name of the resident in room 111A and the bottom basin was not labeled. An unlabeled bedpan was on the left side of the bottom rack that contained 2 unlabeled urine hats. On the right side of the bottom rack were 2 bath basins stacked in one another. The top bath basin was not labeled and the bottom basin was labeled with the name of the resident in 113B.</p> <p>An observation of the bathroom shared by the residents in rooms 111 and 113 on 10/12/11 at 8:40 AM revealed 2 bath basins on the top right shelf stacked in one another, one labeled and one not labeled. An unlabeled bed pan was on the left side of the bottom rack that contained 2 unlabeled urine hats. On the right side of the bottom rack 2 bath basins were observed to be stacked in one another, one was labeled and one was not labeled.</p>	F 253	<p>Disclaimer Statement</p> <p><i>Universal Health Care acknowledges the receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance.</i></p> <p><i>Universal Health Care's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute as admission that any</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Orlando Green* TITLE: Administrator (X6) DATE: 11-3-2011

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 disclosable 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 disclosable 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.

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F 253	Continued From page 1 Nursing Assistant (NA) #1 stated in an interview on 10/12/11 at 9:57 AM that bed pans and bath basins were to be labeled and put in plastic bags and stored on the rack in the resident ' s bathroom. NA #2 stated in an interview on 10/12/11 that bed pans and bath basins were supposed to be labeled with the resident ' s name and room number and stored in plastic bags on the shelf in the bathroom. Nurse #1 stated in an interview on 10/12/11 at 10:43 AM that bed pans and bath basins were to be stored in plastic bags on the shelves in the bath room. The Nurse stated that the resident ' s name or bed number should be written with a sharpie on the bed pans and bath basins. In an interview with the Administrator and the Director of Nursing (DON) on 10/12/11 at 10:46 AM, the Administrator stated that bed pans and bath basins should be stored in plastic bags in the bathroom and should not be stacked inside each other with being in plastic bags and they should be labeled with a permanent marker. On 10/12/11 at 11:10 AM the DON stated that the facility did not have a written policy for the storage of bed pans and bath basins. On 10/12/11 at 11:32 AM the Administrator stated that bath basins were now labeled and in plastic bags. 2. On 10/11/11 at 10:30 AM an observation of the bathroom shared by the 4 residents in rooms 112	F 253	deficiency is accurate. Further, Universal Health Care reserves the Right to refute any of the deficiencies on the Statement of Deficiencies through Informal Dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 253 4 residents in rooms 111 and 113 received new bath basins and bed pans. Urine hats were removed from rooms 111 and 113. New bath basins, and bed pans received by residents in rooms 111 and 113 were labeled with the name of each resident.	11/11/2011 11/11/2011	

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F 253	Continued From page 2 and 114 revealed an unlabeled bath basin on the top rack and an unlabeled bath basin on the bottom rack over the toilet in the bathroom. On 10/12/11 at 8:43 AM there was an unlabeled bath basin on the top rack and an unlabeled bath basin on the bottom rack over the toilet in the bathroom. Nursing Assistant (NA) #1 stated in an interview on 10/12/11 at 9:57 AM that bed pans and bath basins were to be labeled and put in plastic bags and stored on the rack in the resident ' s bathroom. NA #2 stated in an interview on 10/12/11 that bed pans and bath basins were supposed to be labeled with the resident ' s name and room number and stored in plastic bags on the shelf in the bathroom. Nurse #1 stated in an interview on 10/12/11 at 10:43 AM that bed pans and bath basins were to be stored in plastic bags on the shelves in the bath room. The Nurse stated that the resident ' s name or bed number should be written with a sharpie on the bed pans and bath basins. In an interview with the Administrator and the Director of Nursing (DON) on 10/12/11 at 10:46 AM, the Administrator stated that bed pans and bath basins should be stored in plastic bags in the bathroom and should not be stacked inside each other with being in plastic bags and they should be labeled with a permanent marker. On 10/12/11 at 11:10 AM the DON stated that the facility did not have a written policy for the storage of bed pans and bath basins.	F 253	Current residents with bed pans, urine hats and bath basins were observed by the Administrator on 10/12/2011 for proper storage and labeling. All Nursing staff has been retrained on proper storage and labeling of personal care equipment by the DON on 10-12-2011. The Administrator will monitor for the proper storage of bed pans, bath basins and urine hats weekly for 4 weeks then monthly for 2 months utilizing the personal care equipment quality improvement tool with follow up taken for any potential identified issues of concern as appropriate. The Quality Executive Committee will review the quality improvement results quarterly to ensure continued compliance in this area.	11/11/2011 11/11/2011 11/11/2011 11/11/2011	

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F 253	<p>Continued From page 3</p> <p>On 10/12/11 at 11:32 AM the Administrator stated that bath basins were now labeled and in plastic bags.</p> <p>3. On 10/11/11 at 3:00 PM an observation of the bathroom shared by the 4 residents in rooms 133 and 135 revealed 2 bath basins on the left side of the rack in the bathroom stacked in one another. The top basin was labeled with the resident ' s name in 135B and the bottom basin was labeled with the resident ' s name in 135A. The bath basins were not in plastic bags. There were 2 bath basins stacked in one another on the right side of the shelf. The bottom basin was labeled with the name of the resident residing in 133B and the other basin was not labeled.</p> <p>On 10/12/11 at 8:49 AM an observation of the bathroom shared by the 4 male residents in rooms 133 and 135 revealed 2 bath basins stacked in one another on the left side of the rack over the toilet. The top basin was labeled with the resident ' s name in 135B and the bottom basin was labeled with the resident ' s name in 135A. The bath basins were not in plastic bags. There were 2 bath basins stacked in one another on the right side of the rack. The bottom basin was labeled with the name of the resident residing in 133B and the other basin was not labeled. There was an unlabeled urinal sitting on the top of the toilet in the bathroom.</p> <p>Nursing Assistant (NA) #1 stated in an interview on 10/12/11 at 9:57 AM that bed pans and bath basins were to be labeled and put in plastic bags and stored on the rack in the resident ' s bathroom.</p>	F 253			

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F 253	Continued From page 4 NA #2 stated in an interview on 10/12/11 that bed pans and bath basins were supposed to be labeled with the resident ' s name and room number and stored in plastic bags on the shelf in the bathroom. Nurse #1 stated in an interview on 10/12/11 at 10:43 AM that bed pans and bath basins were to be stored in plastic bags on the shelves in the bath room. The Nurse stated that the resident ' s name or bed number should be written with a sharpie on the bed pans and bath basins. In an interview with the Administrator and the Director of Nursing (DON) on 10/12/11 at 10:46 AM, the Administrator stated that bed pans and bath basins should be stored in plastic bags in the bathroom and should not be stacked inside each other with being in plastic bags and they should be labeled with a permanent marker. On 10/12/11 at 11:10 AM the DON stated that the facility did not have a written policy for the storage of bed pans and bath basins. On 10/12/11 at 11:32 AM the Administrator stated that bath basins were now labeled and in plastic bags.	F 253		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 312	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to ensure that resident 's nails were clean for 3 of 5 residents that required extensive to total assistance with activities of daily living (Residents # 4, 6, and 10). The findings include: 1. The facility policy titled Care of Nails and dated 02/1992 under Objective read: " 1. To provide cleanliness. 2. To prevent infection. " The policy under NOTE read in part: " Nail care can be done in the bath or directly after. " Resident #4 was originally admitted to the facility on 04/26/01 and had diagnoses including Dementia. The Significant Change Minimum Data Set (MDS) Assessment dated 08/09/11 showed that the resident had short and long term memory loss and was cognitively impaired. The MDS showed that the resident required extensive assistance with hygiene and bathing. The MDS indicated that the resident had no behaviors. The Care Area Assessment for Activities of Daily Living (ADLs) dated 08/09/11 showed that the resident required extensive assistance for ADLs. The resident ' s Care Plan updated on 08/11/11 showed that the resident had a self care deficit in grooming and bathing related to cognitive deficits. The care plan directed staff to encourage the resident to participate in grooming but did not specifically address nail care.	F 312	F 312 Residents #4, #6 and #10 received nail care on 10-12-2011 by the assigned NA. Residents residing in the facility have been identified as having the potential to be affected by this citation. Current residents have been reviewed by the DON for proper nail care with follow up taken for areas of concern to include re-training and documentation. All licensed nurses and certified nursing assistants were in-serviced on nail care by the DON on 10-12-2011. The in-service included provision of nail care during shower or bath time and as indicated. The DON will monitor nail care weekly utilizing the clinical checklist quality improvement tool for 4 weeks and then monthly for 2 months.	11/11/2011 11/11/2011 11/11/2011 11/11/2011 11/11/2011

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F 312	Continued From page 6 On 10/11/11 at 10:20 AM Resident #4 was observed to be sitting in a chair in her room. The resident was observed to have dark matter under her fingernails. On 10/12/11 at 8:37 AM the resident was sitting in her room eating breakfast. The resident was observed to have dark matter under the fingernails. On 10/12/11 at 9:11 AM, Nursing Assistant (NA) #3 stated in an interview that the residents received nail care but could not say who was responsible for doing the nail care or when it was done. On 10/12/11 at 9:23 AM, NA #4 stated in an interview that the NAs do the nail care and that she did nail care whenever her residents needed nail care. On 10/12/11 at 10:40 AM NA #2 stated in an interview that fingernails were cleaned and cut with the bath or whenever needed. Nurse #1 stated in an interview on 10/12/11 at 10:43 AM that fingernails should be cleaned and cut during the bath if needed. During an interview with the Administrator and Director of Nursing (DON) on 10/12/11 at 10:46 AM, the Administrator stated that the NAs can clean resident 's nails even if the resident is a diabetic and that nails should be cleaned every day with the bath.	F 312	The Quality Executive Committee will review the quality improvement audit results monthly for 3 months and then quarterly.	11/11/2011	

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F 312	<p>Continued From page 7</p> <p>On 10/12/11 at 3:01 PM an observation of the resident ' s fingernails was made with Nurse #2. The Nurse stated that the resident ' s nails needed to be cleaned.</p> <p>2. The facility policy titled Care of Nails and dated 02/1992 under Objective read: " 1. To provide cleanliness. 2. To prevent infection. " The policy under NOTE read in part: " Nail care can be done in the bath or directly after. "</p> <p>Resident #6 was admitted to the facility on 06/09/11 and had diagnoses including Dementia.</p> <p>The Care Area Assessment for Activities of Daily Living dated 06/16/11 showed that the resident required extensive assistance for most of his activities of daily living (ADLs).</p> <p>The Quarterly Minimum Data Set (MDS) Assessment dated 09/11/11 showed that the resident had short and long term memory loss and had poor decision making ability requiring cues and supervision. The MDS showed that the resident required extensive assistance for personal hygiene and bathing.</p> <p>The resident ' s Care Plan updated 09/19/11 included that the resident had a self care deficit with ADLs and required extensive assistance for most ADLs. The care plan did not address nail care.</p> <p>On 10/11/11 at 3:00 PM, resident #6 was observed sitting in a wheelchair in his room. The resident was observed to have dark matter under the fingernails.</p>	F 312			

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F 312	<p>Continued From page 8</p> <p>On 10/12/11 at 8:49 AM the resident was observed sitting in a wheelchair in his room. The resident was observed to have dark matter under the fingernails.</p> <p>On 10/12/11 at 9:11 AM, Nursing Assistant (NA) #3 stated in an interview that the residents received nail care but could not say who was responsible for doing the nail care or when it was done.</p> <p>On 10/12/11 at 9:23 AM, NA #4 stated in an interview that the NAs do the nail care and that she did nail care whenever her residents needed nail care.</p> <p>On 10/12/11 at 10:40 AM NA #2 stated in an interview that fingernails were cleaned and cut with the bath or whenever needed.</p> <p>Nurse #1 stated in an interview on 10/12/11 at 10:43 AM that fingernails should be cleaned and cut during the bath if needed.</p> <p>During an interview with the Administrator and Director of Nursing (DON) on 10/12/11 at 10:46 AM, the Administrator stated that the NAs can clean resident ' s nails even if the resident is a diabetic and should be cleaned every day with the bath.</p> <p>On 10/12/11 at 3:00 PM the resident was observed to have clean finger nails.</p> <p>3. The facility policy titled Care of Nails and dated 02/1992 under Objective read: " 1. To provide cleanliness. 2. To prevent infection. " The policy under NOTE read in part: " Nail care can be</p>	F 312			

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F 312	<p>Continued From page 9 done in the bath or directly after. "</p> <p>Resident #10 was admitted to the facility on 04/29/11 and had diagnoses including Diabetes and Dementia.</p> <p>The Care Area Assessment for Cognitive Loss/Dementia dated 05/05/11 read in part: " Resident has Dementia with severe cognitive impairment. Resident usually understands others. Staff routinely anticipates needs. "</p> <p>The Quarterly Minimum Data Set (MDS) Assessment dated 08/24/11 showed that Resident #10 had severe cognitive impairment and was totally dependent on staff for personal hygiene and bathing.</p> <p>The resident ' s Care Plan updated 09/23/11 showed that the resident ' s fingernails were to be trimmed by the nurse.</p> <p>On 10/12/11 at 9:11 AM, Nursing Assistant (NA) #3 stated in an interview that the residents received nail care but could not say who was responsible for doing the nail care or when it was done.</p> <p>On 10/12/11 at 9:23 AM, NA #4 stated in an interview that the NAs do the nail care and that she did nail care whenever her residents needed nail care.</p> <p>On 10/12/11 at 9:30 AM the resident was observed to be sitting in a wheelchair in his room and was observed to have dark matter under the fingernails.</p>	F 312			

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F 312	Continued From page 10 On 10/12/11 at 10:40 AM NA #2 stated in an interview that fingernails were cleaned and cut with the bath or whenever needed. Nurse #1 stated in an interview on 10/12/11 at 10:43 AM that fingernails should be cleaned and cut during the bath if needed. During an interview with the Administrator and Director of Nursing (DON) on 10/12/11 at 10:46 AM, the Administrator stated that the NAs can clean resident ' s nails even if the resident is a diabetic and should be cleaned every day with the bath. On 10/12/11 at 11:13 AM an observation of the resident ' s fingernails was made with Nurse #2. The Nurse stated that the resident ' s fingernails were dirty and that she would let the treatment nurse know. Nurse #2 stated that the nursing assistants could clean the nails of diabetic residents but that she preferred the treatment nurse to do it.	F 312			
F 441 SS=E	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,	F 441			

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F 441	Continued From page 12 13) for one of three residents with current IVs; failed to post CDC recommended signage for residents on contact isolation for Residents #12 and #13; failed to provide a isolation cart for a resident in contact isolation Resident #12; and failed to maintain aseptic technique for the administration of eye drops (Resident #6 for 1 of 1 residents observed on the medication pass with eye drop; for 3 of 4 isolation rooms (Residents #6, Resident #12 and Resident #13) Findings include: Facility policy for removing PPE was obtained from the Director of Nursing on 10/12/11 at 11:15 AM; it stated that all PPE and waste should be discarded in the waste or linen bins provided in each contact isolation room. Facility ' s Infection Control Manual, Contact Precautions, Isolation (undated) was provided. " Contact Precautions may be considered for (examples): Multi-resistant organisms (e.g., MRSA, VRE (Vancomycin Resistant Enterococcus) (page 7). " 1.A Resident # 13 was admitted to the facility on 10/07/11 with septic left knee with MRSA (methicillin resistant staphylococcus aureus), s/p (status post) hardware removal, diabetes and chronic respiratory failure. Hospital discharge records indicate the reason for admission was " need antbx (antibiotic) therapy. " During the observation of a medication pass on 10/12/11 at 8:40 AM, Nurse #1 was preparing to hang an intravenous bag of Vancomycin (an antibiotic used to treat drug resistant strains of Staphylococcus aureus). Nurse #2 removed the	F 441	Housekeeping staff has been in-serviced on 10-11-2011 by the Administrator on the CDC recommended solutions acceptable for blood spill disinfection and cleaning. Nursing staff has been retrained on 10-12-2011 by the DON regarding the proper disposal of contaminated equipment in a contact isolation room and on posting of CDC recommended signage for isolation rooms. CDC recommended signage for residents on contact isolation has been posted. Licensed Nurses and medication Aides were re-trained on 10-12-2011 by the DON regarding the aseptic technique for administration of eye drops. The DON and ADON will continue to in-service staff quarterly to ensure infection control procedures are followed according to CDC guidelines.	11/11/2011 11/11/2011 11/11/2011 11/11/2011

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PRINTED: 10/26/2011
FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 13</p> <p>used bag of Vancomycin and went to the provided trash bin to discard the intravenous equipment. There was no liner in the trash bin. The nurse indicated the resident was on contact isolation. The nurse then discarded the contaminated equipment in the resident trash can. The nurse then hung the new dose of antibiotic. She then removed the used IV equipment in a resident 's trash can (instead of the infection control bin), tied the bag, exited the room, and deposited the bag in the medication cart trash receptacle. She stated she was going to take the bag to the soiled utility room to dispose of it but she had to get more water in her pitcher. She refilled the water pitcher and continued down the hall to another isolation room (Resident #6). *She was unaware that she had not properly disposed of contaminated equipment until the surveyor mentioned it to her.</p> <p>The nurse stated she was nervous being chosen for medication pass and forgotten to dispose of the used IV equipment. She then took the liner with the contaminated equipment to the soiled utility room.</p> <p>Facility 's Infection Control Manual, Contact Precautions, Isolation (undated) was provided. " Contact Precautions may be considered for (examples): Multi-resistant organisms (e.g., MRSA, VRE (Vancomycin Resistant Enterococcus) (page 7). "</p> <p>1.B Resident # 13 was admitted to the facility on 10/07/11 with septic left knee with MRSA (methicillin resistant staphylococcus aureus), s/p (status post) hardware removal, diabetes and chronic respiratory failure. Hospital discharge</p>	F 441	<p>Monitoring will be done by the DON and ADON weekly for 4 weeks and monthly thereafter using resident observation and Quality Improvement audits.</p> <p>The Quality Executive Committee will review findings monthly for 6 months and then quarterly to ensure continued compliance in this area.</p>	<p>11/11/2011</p> <p>11/11/2011</p>

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F 441	<p>Continued From page 14</p> <p>records indicate the reason for admission was " need antbx (antibiotic) therapy. "</p> <p>During observation of the medication pass on 10/12/11 at 8:40 AM, there was an isolation cart outside the resident ' s room stocked with disposable masks, gowns, gloves and a hand sanitizer bottle with a pump spray. There was no signage on the door to indicate what type of isolation the resident was in (droplet, contact or enteric); what precautions to take when entering or exiting the room or reminders to visitors to ascertain what precautions they should take. In an interview with the nurse at 8:50 AM she stated the resident was in contact isolation.</p> <p>Observations on a repeat tour of the facility on 10/12/11 at 9:30 AM revealed three rooms with isolation carts; only one of the rooms had signage for contact isolation and the isolation cart (Room 122). Residents # 6 and #13 had an isolation cart but was no signage on the door to indicate what type of isolation the resident was in (droplet, contact or enteric); what precautions to take when entering or exiting the room or reminders to visitors to ascertain what precautions they should take.</p> <p>An observation of Resident 12 ' s room on the tour revealed an IV pump but no signage and no isolation cart. Record review of Resident #12s chart and observation of the IV pump in the room revealed the resident was on Daptomycin (Cubicin) for treatment of MRSA in an infected knee where the hardware prosthesis had also been removed. The resident was on contact isolation.</p> <p>There was no signage on the door to indicate what type of isolation the resident was in (droplet,</p>	F 441			

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F 441	<p>Continued From page 15</p> <p>contact or enteric); what precautions to take when entering or exiting the room or reminders to visitors to ascertain what precautions they should take.</p> <p>In an interview with the Director of Nursing on 10/12/11 at 11:30 AM, the surveyor asked what the facility policy was for isolation set up. A copy of the Facility 's Infection Control Manual, Contact Precautions, Isolation (undated) was provided. " Contact Precautions may be considered for (examples): Multi-resistant organisms (e.g., MRSA, VRE (Vancomycin Resistant Enterococcus) (page 7). " The corporate representative stated that she would check with her corporate nurse to see if signs were mandatory. It was established that per CDC recommendations, signage should be on the doors stating the type of isolation and the precautions necessary before entering and on leaving the room. On 10/12/11 at 11:56 AM, Resident #12 and #13 in isolation had signage on the door and infection control carts and Resident #6 who was no longer in isolation had the isolation cart removed.</p> <p>Interview with the Director of Nursing and corporate VP on 10/12/11 at 3:00 PM revealed that the chain of control for isolation should be: 1 the admitting nurse would ascertain from the attending physician whether a resident should be placed in isolation and what type of isolation should be instituted. 2. The floor nurse should contact central supply for an infection control cart and a sign for the door. 3 the Director of Nursing should be notified that isolation procedures were</p>	F 441			

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F 441	<p>Continued From page 16</p> <p>instituted. 4. Central Supply would be responsible for the par levels of gowns, gloves, masks on the cart. If antibiotic treatments (oral or IV) were indicated by the hospital discharge orders, the attending physician would concur with the stop date. When the treatment was finished the floor nurse would contact the attending physician to see if further culturing was needed or if isolation procedures should be discontinued and the signage and carts could be removed.</p> <p>2. During the observation of the medication pass for Resident #6, on 10/12/11 at 8:58 the nurse poured the oral solid medications at the cart and then withdrew a bottle of Timoptic (Timolol) ophthalmic solution from the top drawer of the medication cart. She entered the room and gave the resident the cup of oral solid medications. She then placed the bottle of capped Timoptic and the clean gloves on the resident ' s side chair while she entered the bathroom to wash her hands. She came out of the bathroom retrieved the medication and gloves from the chair and administered the medication. She washed her hands and returned to the medication cart. Standards of Practice for administration of eye drops published by Med-Pass through the American Society of Consultant Pharmacist stated that an ophthalmic solution " Remove medication cap and place on clean dry surface " ; a barrier such as a clean paper towel can be used on the overbed table to hold supplies; the top is then replaced on the bottle, the medication remains on the clean surface while the nurse ' s hands are washed, the towel is discarded and the bottle replaced in the dispensing sleeve at the medication cart.</p>	F 441			

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F 441	Continued From page 17 The facility policy on the Infection Control Manual, Housekeeping Services, Department Policies (undated) on page 9 stated, " Cleaning Blood Spills. Blood spills will be cleaned using an approved blood spill kit. The spill kit manufacturer ' s recommendations for cleaning and decontaminating the spill will be followed. As an alternative, a fresh 1:10 dilution of bleach may be used. Gloves and other appropriate personal protective equipment (based on the specific situation) will be worn. " 3. Observation of the hall floors during tour on the 10/12/11 at 8:30 AM, the floor were spotted with dried brownish liquid. On 10/11/11 at 9:15 AM Housekeeper #1 was asked how she would clean up a blood spill if she were called to a room or discovered blood on the floor. She stated that she would use the " red and white kit. " When asked where she would obtain this kit, she stated the soiled utility room. Housekeeper #1 escorted the surveyors to the soiled utility room but no kits were available. At 9:20 AM, the surveyor approached the nursing station and asked the three staff (Dietary Manager, MDS nurse and Nurse #1) seated there if blood was discovered on the floor how they would ensure appropriate clean-up. The MDS nurse stated there was a kit for that. When asked where they would obtain the kit, they stated they supposed the kits were in the soiled utility room. The Dietary Manager was asked if she had a spill kit in case some was injured in the kitchen. The Dietary Manger stated she was going to Central Supply to get a spill kit and she would inservice her staff on when and how to use the spill kit for blood spills on both day and	F 441			

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F 441	<p>Continued From page 18 evening shift.</p> <p>In an interview with the Housekeeping Director at 9:45 AM, she was asked how she would clean up a blood spill or direct her staff to clean blood spills. She took the surveyors to the housekeeping closet and showed them a standard cleaning solution in a quart plastic bottle which would be adequate for routine cleaning and a gallon bottle of a quaternary solution which would be adequate for disinfection. She was unaware that facility policy designated a specific kit for blood spills containing bleach in a 1:10 dilution.</p> <p>In an interview with the Director of Nursing on 10/11/11 at 10 AM, she was asked for the policy on blood spills.</p> <p>The Maintenance Director entered the room during the interview and obtained the policy. The facility policy on the Infection Control Manual, Housekeeping Services, Department Policies (undated) on page 9 stated, " Cleaning Blood Spills. Blood spills will be cleaned using an approved blood spill kit. The spill kit manufacturer ' s recommendations for cleaning and decontaminating the spill will be followed. As an alternative, a fresh 1:10 dilution of bleach may be used. Gloves and other appropriate personal protective equipment (based on the specific situation) will be worn. " When asked if he knew where the kits were kept, he stated ' yes ' the kits were in the central supply room. A visit to the central supply room revealed a box of kits on the shelf.</p> <p>The Universal Spill Kit contained gloves, a biohazard plastic mask to protect the eyes, a poly backed towel to cover the blood spill, a trash liner, plastic scoop and tie, 2 Quick Up Absorbent Beads (the beads absorb the blood spill like kitty</p>	F 441			

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F 441	Continued From page 19 litter and then the scoop is used to transfer the solid mass to the included trash liner), 2 antiseptic wipes and 1 Germicidal Sani cloth.	F 441			