

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

PRINTED: 11/19/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/02/2007
NAME OF PROVIDER OR SUPPLIER SUMMIT HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 506 NORTH LONG AVENUE TAYLOR, AR 71861	
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F 000	INITIAL COMMENTS	F 000		
F 282 SS=E	<p>Complaint #12892 was unsubstantiated.</p> <p>483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure supplements were provided as ordered by the Physician for 1 of 1 (Resident #6) case mix resident who required nutritional supplements with meals. This failed practice had the potential to affect 1 resident who required nutritional supplements with meals, according to the Director of Nursing on 11/2/07. The findings are:</p> <p>Resident #6 had diagnoses of Seizures, Alzheimer's Disease and Dementia. The Quarterly Minimum Data Set (MDS) dated 10/9/07 documented the resident had severely impaired cognitive skills for daily decision making, had total dependence on staff for eating and had a weight change.</p> <p>a. The Care Plan dated 10/9/07 documented, "Problem... At risk for compromised nutritional status due to weight loss/Alzheimer's Dementia... Approaches... Provide diet as ordered per MD (medical doctor)."</p> <p>b. The Physician Order dated 10/11/07 documented, "Magic cup TID (three times a day)</p>	F 282		

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

TITLE

(X6) DATE

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 282	Continued From page 1 [with] meals..." c. The Dietary notes dated 10/25/07, documented, "...Magic cup TID to increase calories and protein... Magic Cup 290 calories and 9 grams protein..." d. On 10/29/07 at 5:35 p.m., the resident was served a regular pureed diet for the dinner meal, but no Magic Cup. The diet card listed, Magic cup for breakfast, lunch and dinner. e. The weekly weight list, received from the Director of Nursing on 10/30/07, documented the resident's weight for 10/1/07 was 150 pounds and the weight documented for 10/29/07 was 145.5 pounds, for a weight loss calculated at 3%. f. On 10/31/07 at 12:30 p.m., the resident was served a regular pureed diet for the lunch meal, but did not have a Magic cup on the tray. g. On 10/31/07 at 5:30 p.m., the resident was being spoon fed a regular pureed diet with a 4-ounce container of ice cream on the tray for the dinner meal. There was no Magic cup on the resident's tray. The resident did not receive the Magic cup to provide additional calories and protein to supplement the nutritional intake and no other supplement was offered by the staff during the meal service.	F 282			
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING 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 2 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure urine was cleansed from the skin before application of a clean brief for 1 (Residents #2) of 6 (Residents #2 and #5 through #9) case residents who required assistance with incontinent care and nails were trimmed for 1 (Resident #2) of 4 (Residents #1,#2, #6 and #7) case mix residents who required a podiatrist for nail care. These failed practices had the potential to affect 35 residents who were incontinent, according to the Resident Census and Conditions of Residents form dated 10/30/07 and 19 residents who required a podiatrist for nail care, according to a list provided by the Director of Nursing (DON) on 11/1/07. The findings are: 1. Resident #2 had diagnoses of Incontinence, Dyspnea, Morbid Obesity, Congestive Heart Failure, Depression and Hypertension. The Minimum Data Set (MDS) dated 10/1/07 documented the resident had independent cognitive skills for daily decision-making, required limited assistance of one person for personal hygiene, was incontinent of bowel and bladder and had no nails/calluses trimmed during the last 90 days. a. The Policy and Procedure on Incontinence Care, received from Administration on 11/1/07 at 7:55 a.m., documented: "Purpose; 1. Keep skin clean, dry, free of irritation and odor. 2. To identify skin problems as soon as possible so treatment can be started. 3. To prevent skin breakdown. 4. To prevent infection... Procedure... 3. Wash all soiled skin areas,	F 312			

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F 312	<p>Continued From page 3</p> <p>especially between skin folds with soap and water and/or peri-wash/wipes. 4. Wipe front to back with clean area of cloth at each stroke, then dry well. 5. May apply protective skin lubricant and rub well into skin. 6. Change any soiled linen. 7. Use incontinence pad, as necessary."</p> <p>1) The Resident Plan of Care updated 10/01/07 documented: Incontinent of Bowel and Bladder; at risk for [Urinary Tract Infection], Approach- Keep Clean and Dry, Incontinent Care every two hours and [as needed], ...</p> <p>2) On 10/30/07 at 10:30 a.m., Certified Nursing Assistant (CNA) #1 and CNA #2 came into the resident's room to transfer the resident from the bed to a wheelchair, using the mechanical lift. CNA #1 changed the resident's brief, which was yellow stained and wet, and put a dry brief on the resident.</p> <p>The CNA was then asked, How often are you supposed to do incontinent care? She stated, "Every two hours I wipe them up and change the diaper, but I gave the resident a bath at 8:00 a.m." No incontinent care was performed and resident was transferred to a wheel chair.</p> <p>b. The Policy and Procedure on Nails, Care of (Finger and Toe), received from Administration on 11/1/07 at 7:55 a.m., documented: "Purpose; 1. To provide cleanliness. 2. To prevent spread of infection. 3. For comfort 4. To prevent skin problems. General Guidelines for assessment may include, but are not limited to: Presence of pain or discomfort, Peripheral circulation, Diagnoses predisposing to infection: a. Diabetes b. Peripheral vascular disease, Anemia, Malnutrition, Lesions or irritation on finger or</p>	F 312			

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F 312	<p>Continued From page 4</p> <p>toes... General Documentation Guidelines Frequency of documentation should follow facility policy. Documentation May include: Condition of hands, feet and nails, if unusual observations noted in nurses notes and Weekly Skin Audit, Notify the physician of any condition changes, when appropriate, Signature and title. Problem: Identify the appropriate problem that requires finger and toe nail care. Consider listing possible risks and complications."</p> <p>1) On 10/30/07 at 10:40 a.m., the resident was in his wheelchair and had not had his house shoes put on yet by the CNA. The resident was noted to have extremely long toenails with a yellowed build-up under the all ten toenails. The left great toe had a Band-Aid on it dated 10/30/07.</p> <p>When the surveyor noted the Band-Aid on his left great toe, the resident stated "The toenail is coming off. No one has the guts to cut it."</p> <p>2) The Physician Order Sheet dated 10/1/07 through 10/31/07 documented, 7/06/07 Treatment apply TAO (Triple Antibiotic Ointment) and secure left great toe nail with Band-Aid daily.</p> <p>3) The Weekly Skin Audit Record was reviewed 8/01/07 through 9/26/07 and documented each week "L (left) gr (great) toe nail loose" for a total of nine weeks. There were no new interventions other than TAO and a Band-Aid every day. The nails have not been trimmed nor has the resident been seen by a podiatrist.</p> <p>4) On 11/1/07 at 9:25 a.m., the Director of Nursing stated that the resident "fell through the cracks" because he did not have a diagnosis to allow him to be seen by a podiatrist.</p>	F 312			

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F 314 SS=D	<p>483.25(c) PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure incontinent care was provided in a timely manner and the skin was cleansed of urine/feces to prevent the potential for skin breakdown for 2 (Residents #2 and #7) of 6 (Residents #2 and #5 through #9) case residents who required assistance with incontinent care. This failed practice had the potential to affect 35 residents who were incontinent, according to the Resident Census and Conditions of Residents form dated 10/30/07. The findings are:</p> <p>1. The Policy and Procedure on Incontinence Care, received from Administration on 11/1/07 at 7:55 a.m., documented: "Purpose; 1. Keep skin clean, dry, free of irritation and odor. 2. To identify skin problems as soon as possible so treatment can be started. 3. To prevent skin breakdown..."</p> <p>2. Resident #7 had diagnoses of Insulin Dependent Diabetes Mellitus, Aspiration Pneumonia, Cerebrovascular Accident and Incontinence. The Medicare 14-Day Minimum</p>	F 314			

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F 314	Continued From page 6 Data Set (MDS) dated 9/20/07 documented the resident had severely impaired cognitive skills for daily decision making, was incontinent of bowel and bladder and was totally dependent on staff for all activities of daily living. a. The Resident Plan of Care dated 10/12/07 documented, "At risk for pressure sore/sores related to incontinence of B&B (bowel and bladder)... Approaches - Incontinent care after every episode. Skin care daily and prn (as needed)." b. On 10/30/07 at 10:45 a.m., the resident's brief was marked with a black ink pen on the left side, near the lower tape. c. On 10/30/07 at 12:15 p.m., the treatment nurse was at the bedside conducting a skin assessment. When the resident's buttocks were checked, the mark on the brief was present. A small to moderate amount of soft, brown, pasty stool was present on the resident. The buttocks and the stool were observed and the nurse refastened the brief. d. On 10/30/07 at 1:05 p.m., the resident's marked brief was still in place. e. On 10/30/07 at 1:30 p.m., the DON was asked to observe the resident's condition. The incontinence brief was removed to allow viewing of the rectal area and there was brown feces present on the resident's skin and on the incontinence brief. The surveyor's mark was present and the DON was informed that the brief was marked at 10:45 a.m.	F 314			
F 329 SS=E	483.25(l) UNNECESSARY DRUGS	F 329			

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F 329	<p>Continued From page 7</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure residents were free from duplicate medication therapy, had indications for use of medications and had adequate monitoring of drugs with similar side effects for 1 (Resident #12) of 4 (Residents #1, #2, #4 and #12) case mix resident who received scheduled pain medications. This failed practice had the potential to affect 9 residents in the facility, as identified on a list provided by the Director of Nursing on 11/2/07 at 10:00 a.m. The findings</p>	F 329			

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F 329	Continued From page 8 are: Resident #12 had diagnoses of Hypothyroidism, Insomnia and Severe Anorexia. The Significant Change Minimum Data Set (MDS) dated 10/11/07 documented the resident had independent cognitive skills for daily decision making, had no pain and had a fall in the past 30 days. a. The resident had the following Physician orders, 1) 11/16/06 - Lyrica 75 mg (milligram) one po (by mouth) tid (3 times daily). 2) 12/29/06 - Ultram (Tramadol) 50 mg tab (tablet) one or two PO Q 6 hr (hour) prn (as needed) pain. Do not exceed 8 tabs in 24 hours. 3) 7/11/07 - Ultram (Tramadol) 50 mg tabs 2 PO TID. 4) 9/20/07 - Ibuprofen 200 mg tab 2 = 400 mg po tid with food. b. On 11/1/07 at 8:45 a.m., the resident stated she took Ultram 3 times a day for arthritis pain in her knees. She stated that she had a fall about 3 weeks ago. The resident stated that she did not remember what happened but thought she "blacked out." The resident stated that she was sent to the hospital "to be checked out" and that she was now well, "except sore all over." She stated, "Arthritis is my only pain." c. On 11/1/07 at 4:00 p.m., the DON stated, "[Resident #12] fell and nothing was broken. [Resident #12] was reluctant to get up. That's the only one [fall] I know of." The DON stated, "She	F 329		

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F 329	<p>Continued From page 9</p> <p>is on Lyrica. She complains to the doctor about how bad her arthritis pain [is]. She doesn't complain to us [nurses] about pain. She doesn't ask for pain medication [from nurses]."</p> <p>d. The Nurse's Notes dated 9/29/07 at 2030 [8:30 p.m.] documented the resident was found, "on the floor." The note documented the resident stated, "I just got dizzy and fell."</p> <p>e. The Medication Record for October 2007 documented the resident was administered the following 3 scheduled pain medications simultaneously at the same 3 medication administration times:</p> <p>1) Ultram 50 mg tabs 2 tid (3 times daily) at 8 a.m., 12 noon, and 4 p.m.;</p> <p>2) Lyrica 75 mg 1 tab tid (3 times daily) at 8 a.m., 12 noon, and 4 p.m.; and</p> <p>3) Ibuprofen 200 mg tabs 2 (400 mg) tid (3 times daily) at 8 a.m., 12 noon, and 4 p.m.</p> <p>f. The Lexi Comp Geriatric Dosage Book, 12th Edition, pages 1284 -1286 for Pregabalin or Lyrica ® documented the maximum geriatric/adult dose as 300 mg per day. Adverse Reactions included, "Dizziness..".</p> <p>g. The Lexi Comp Geriatric Dosage Book, 12th Edition, pages 767-769 for Ibuprofen documented there is, "an increased risk of gastrointestinal irritation, ulceration, and bleeding... Use with caution with ...concurrent therapy with corticosteroids...(and) the elderly..." Adverse Reactions included, "Dizziness..."</p>	F 329			

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F 329	<p>Continued From page 10</p> <p>h. The Lexi Comp Geriatric Dosage Book, 12th Edition, pages 1569-1572 for Tramadol or Ultram ® documented, "Warnings/Precautions Older adult patients... may be at greater risk of adverse events... Tolerance or drug dependence may result with extended use..." Adverse Reactions included..."Dizziness..."</p> <p>i. Consultant Pharmacy Monthly Review - Documentation and Follow up notes were reviewed for October 2006 through October 2007. In October 2006 the Pharmacist requested that Ultram (which was then prn 50 mg Q 4 hr) be discontinued because of possible allergy. The PRN Ultram was discontinued 12/15/06 and was re-ordered 12/29/06 as 50 mg i or ii PRN.</p> <p>j. The clinical record contained no pain documentation showing the need to increase Ultram to a scheduled medication. The Medication Administration Record documented that in October and November, 2006 no PRN Ultram was administered.</p> <p>1) In January 2007 the resident was administered PRN Ultram 2 times during the month.</p> <p>2) In February 2007 PRN Ultram was given on 3 occasions.</p> <p>3) In March 2007 PRN Ultram was not given.</p> <p>4) In April 2007 PRN Ultram was given on 4 occasions.</p> <p>5) In May 2007 PRN Ultram was not given.</p> <p>6) In June 2007 PRN Ultram was not given.</p>	F 329			

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F 329	Continued From page 11 7) On July 11, 2007, Ultram was changed from a PRN medication at 50 mg i or ii (one or two) to a scheduled medication at 50 mg ii (two) PO tid (or a total of 100 mg 3 times daily. Daily total 300 mg.) The clinical record documented no pain for the months of April through July 2007. As of 11/2/07, there was no documentation in the clinical record to indicate why the Ultram was changed from prn to a scheduled medication. k. The resident's Clinical Record Monthly Summaries dated 4/9/07, 5/9/07, 6/7/07, 7/9/07, 9/9/07, and 10/9/07 all documented "No" for Pain, item #13. l. A Clinical Record Pain Assessment (form) dated 10/11/07 documented, "Resident Diagnosis" including: "Arthritis, Constipation, and Recent falls." Pain Rating Scale documented, "At Present 0 = No Pain." m. The resident's Care Plan dated 10/12/07 for Osteoarthritis documented, At risk for pain and discomfort, documented an intervention to monitor for verbal and nonverbal S&S (signs and symptoms) of pain and to assess pain level. n. As of 11/2/07 at 10:30 a.m., the Administrator and Director of Nursing could not provide evidence that there was a system in place for pain monitoring or that the common side effect of dizziness was monitored for.	F 329			
F 363 SS=D	483.35(c) MENUS AND NUTRITIONAL ADEQUACY Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition	F 363			

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F 363	<p>Continued From page 12</p> <p>Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure their written menu was followed for 1 of 1 (Resident #10) case mix resident who had a physician order for a therapeutic diet. This failed practice had the potential to affect 18 residents who had a physician order for a therapeutic diet, as identified on the facility's Diet List dated 10/29/07. The findings are:</p> <p>1. Resident #10 had diagnoses of Chronic Obstructive Pulmonary Disease, Malnutrition and Depression. The Quarterly Minimum Data Set dated 9/8/07 documented the resident was independent in cognitive skills for daily decision making and required set up help for eating.</p> <p>a. The physician order dated 10/8/07 documented, "2 Gm (gram) Sodium Diet."</p> <p>b. On 10/29/07, the lunch menu for the 2 Gram Sodium diet documented, LS (Low Salt) Roast Turkey Breast, LS Broccoli/Rice Casserole, no Milk and Cream Cake.</p> <p>On 10/29/07 at 12:22 p.m., the resident was served a slice of turkey, plain broccoli with rice, a carton of whole milk and diet cake.</p> <p>c. On 10/29/07, the supper menu for the 2 Gram Sodium diet documented, LS Hamburger patty and LS French Fries.</p>	F 363			

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F 363	Continued From page 13 On 10/29/07 at 5:29 p.m., the resident was served a regular hamburger patty, salted french fries and a carton of milk. d. On 10/30/07, the breakfast menu for the 2 Gram Sodium diet documented, Toast and no meat. On 10/30/07 at 7:41 a.m., the resident was served bacon and one biscuit. e. On 10/30/07, the lunch menu for the 2 Gram Sodium diet documented, low salt Lima Beans. On 10/30/07 at 12:20 p.m., the resident was served baked beans. f. On 10/30/07 at 12:40 p.m., Dietary Employee #2 stated, "French fries were salty when I tested; it was bought that way." g. On 10/30/07 at 12:43 p.m., Dietary employee #1 stated, "We did not have low salt cheese to use in the broccoli/rice casserole for 2 gram [sodium diet]."	F 363			
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the ice machines were free of	F 371			

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F 371	<p>Continued From page 14</p> <p>debris to prevent cross contamination and dietary staff washed their hands between dirty and clean tasks. These failed practices had the potential to affect 52 residents who received their meal trays from the kitchen, as identified on the facility's Diet List dated 10/29/07. The findings are:</p> <p>1. On 10/29/07 at 11:16 a.m., the following observations were made:</p> <p>a. The ice machine, located in the kitchen, where ice was obtained by the Dietary employees and added into the resident's beverages for all meals, had slimy reddish matter on the panel where ice shoots down to the collector bucket.</p> <p>b. The ice machine, located in the dining room, where Certified Nursing Assistants filled resident's room water pitchers with ice, had reddish matter inside the spout where ice shoots down.</p> <p>c. Dietary employee #1, who had gloves on both hands, picked up a serving spoon from the drawer, picked up a pan and placed them on the counter. She picked up two bags of bread and placed them on the counter. She then opened the conventional oven and checked on the food item in the oven. She then picked up a pot from the stove that contained boiled turkey and placed it on the counter. She picked up a tong, used it to pick up boiled turkey from the pot and place in the blender to puree.</p> <p>Without changing gloves, she placed her gloved hand inside the bread bags, removed 5 slices of bread and broke them onto the boiled turkey that was already in the blender. She pureed the turkey and bread to be served to the residents on a</p>	F 371			

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F 371	<p>Continued From page 15 pureed diet.</p> <p>2. On 10/29/07 at 11:25 a.m., Dietary employee #2 who had gloves on both hands, picked up a sauce pan, placed it on the stove, touched the stove knob when turning it on and placed one pork chop in the sauce pan. She picked up the seasoned salt, opened it, placed her gloved hand inside the container, took out some seasoning and sprinkled it on the pork chop.</p> <p>Without changing gloves, she went to the dishwashing machine room and got clean dishes. She got her fingers inside the plates when stacking them up.</p> <p>At 12:38 p.m., Dietary employee #2 was still wearing the same gloves. She picked up a fork and held the pork chop down in the sauce pan with her gloved hand, without changing the gloves.</p> <p>3. On 10/29/07 at 3:50 p.m., Dietary employee #2, who had gloves on her hands opened the oven door, took out a pan that contained hamburger patties and placed the pan on the counter by the steam table. She pushed the utility cart by the side, picked up a pan and placed it on the steam table and then picked up a spatula and placed it on the counter. She picked up the container of seasoned salt, picked up a spoon, scooped some out and sprinkled it on the cooked hamburger patties. Without changing gloves, she used her gloved hand to flip the hamburger patties. She then used the same gloved hand to position the patties on the spatula before transferring them into a pan.</p> <p>4. On 10/29/07 at 4:30 p.m., Dietary employee #2</p>	F 371			

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F 371	Continued From page 16 who had gloves on both hands, wiped her nose with the back of her gloved right hand. She picked up a tong and a bowl that contained 4 hamburger patties and tap water that she had added on the meat. She added 5 more pieces of hamburger patties into the bowl. She then poured the patties in the blender and pureed. While she was pouring the pureed patties in a pan on the steam table, some fell on the steam table. The employee picked up the spilled meat and put it back in the pan that contained pureed meat to be served to the residents on a pureed diet at the lunch meal. She opened the oven and checked on the meat in the oven. She then picked up a wet towel and wiped food that spilled on the counter and then picked up a spoon and stirred squash that was in a pot on the stove. She went to the storage room, came out with a pan and placed it on the counter. She opened the door of the conventional oven and touched the fries. At 4:36 p.m., she opened the oven, took out the pan that contained fries and poured it in a pan. Without changing gloves, she tossed the fries with her gloved hands. 5. On 10/29/07 at 4:48 p.m., Dietary employee #2 removed her gloves, washed her hands and put on set of new gloves. She wiped her nose with the back of her gloved hand. At 5:00 p.m., she pushed trays on the steam table, picked up bread buns, opened the buns and placed them in the resident's plates to be served at the supper meal.	F 371			
F 441 SS=F	483.65(a) INFECTION CONTROL	F 441			

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F 441	<p>Continued From page 17</p> <p>The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure an effective infection control program was maintained for cleaning and disinfecting bath basins used for resident personal care and/or shower chairs used by residents in the 200 Hall Shower Room for 2 (Residents #7 and #11) case mix residents. This failed practice had the potential to affect 45 residents who required bath basins for incontinent care and bed baths, as documented by the Director of Nursing on 11/2/07 and 7 residents who received showers in the 200 Hall shower room, as documented by the Director of Nursing on 11/1/07. The findings are:</p> <p>1. The facility guidelines titled, "Incontinence Care," received on 11/1/07, documented, "Purpose... 4. To prevent infection. ...General Infection Control Guidelines ...3. Gather equipment, maintaining ...cleanliness. ...7. Thoroughly clean all equipment used and return to appropriate storage area."</p> <p>a. Resident #7 had diagnoses of Insulin</p>	F 441			

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F 441	<p>Continued From page 18</p> <p>Dependent Diabetes Mellitus, Aspiration Pneumonia, Cerebrovascular Accident and Incontinence. The Medicare 14-Day Minimum Data Set (MDS) dated 9/20/07 documented the resident had severely impaired cognitive skills for daily decision making, had short/long-term memory problems, incontinent of bowel and bladder, was totally dependent on staff for all activities of daily living, had swallowing problems and had a feeding tube.</p> <p>1) On 10/31/07 at 3:06 p.m., Certified Nursing Assistant (CNA) #3 assisted CNA #4 to provide incontinent care to the resident in her room on the 200 hall. A small plastic wash basin was filled with soap and water and used for provision of the incontinence care. At the conclusion of care, CNA #3 emptied the water in the resident's bathroom. She then took the wash basin to the utility room on the 200 hall. She prepared to "disinfect" the basin and "return it to the cupboard." No disinfectant solution was found in the utility room. The wash basin was left in the sink uncleaned.</p> <p>2) On 11/1/07 at 10:11 a.m., CNA #5 was asked to show the surveyor where bed pans and bath basins were cleaned. She led the way to the soiled utility room and stated, "We clean them and place them in bags. We store them." She opened the cupboard under the sink to show where they were stored. She was asked to explain what the process was. CNA #5 stated, "We clean them with soap and water. We use the soap and water in the resident's bathroom. We use the resident's sink and the soap and water on the wall. Then we bring them to the utility room. We spray it with disinfectant, rinse it and dry it with paper towels." She repeated, "We</p>	F 441			

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F 441	<p>Continued From page 19 spray it down and rinse it off."</p> <p>The Surveyor asked the CNA, "Is this what you use?" referring to a purple solution in a plastic spray bottle. CNA #5 stated, "Yes." When asked who mixed the spray she stated, "I think the housekeeper mixes up the spray."</p> <p>b. Resident #11 had diagnoses of Cerebrovascular Accident and Diabetes Mellitus. The Annual Minimum Data Set (MDS) dated 8/29/07 documented the resident had severely impaired cognitive skills for daily decision-making, had total dependence on staff for activities of daily living for toilet use, personal hygiene and bathing and had an enteral feeding tube.</p> <p>1) On 11/01/07 at 9:30 a.m., Certified Nursing Assistant (CNA) #4 obtained a bath basin from underneath the sink in the Soiled Utility room on the 200 Hall across from the nursing station. The plastic bath basin was inside a clear plastic bag. The CNA took the basin to the supply room and placed personal care supplies of body wash and lotion in the basin and then went into the main supply room to obtain other items. The CNA then went into the resident's room and provided incontinent care to the resident. Following the incontinent care, CNA #5 poured the water out of the basin in the bathroom and bagged in a plastic bag.</p> <p>2) On 11/1/07 at 9:55 a.m., CNA #5 took the basin into the Soiled Utility Room on 200 Hall and removed it from the plastic bag, leaving the bag on the counter next to the large metal sinks. CNA #5 then picked up a spray bottle of purple solution labeled, "Ecolab disinfectant" and sprayed the basin while stated, "I'm going to let it sit a few</p>	F 441			

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F 441	<p>Continued From page 20</p> <p>minutes." The CNA then rinsed the basin with water after the disinfectant was on the basin for 1 minute. She then dried the pan with paper towels, opened the same plastic bag, placed the basin in the plastic bag, opened the cabinet door underneath the sink and placed the bagged basin under the sink ,on top of a bagged bedpan. No gloves were worn by the CNA when the basin was cleaned and dried.</p> <p>c. The label for Neutral Cleaner & Disinfectant [purple solution], received from the Housekeeping Supervisor on 10/31/07 at 4:35 p.m., documented: "Directions for use... Disinfection: ...cleaning of hard non-porous surfaces... Apply solution with a wet cloth, mop, brush, scrubber, or by soaking. Allow to remain wet for at least 10 minutes... prepare a fresh solution at least daily..."</p> <p>d. The facility guidelines, received on 11/1/07, documented, "Bedpans, Urinals, Bedside Commodes, Wash Basins, Emesis Basins 1. Gather soiled items nightly and take to soiled utility room. 2. Scrub items well; all debris must be removed before sanitizing. 3. Clean with solution of two (2) ounces of Disinfectant to one (1) gallon of water. 4. Air dry items and place in individual plastic bags. 5. Return bedpans, urinals, bedside commodes, wash basins, emesis basins to resident's bedside units. 6. If bedpans and urinals are not needed immediately, store in clean area of utility room."</p> <p>e. On 11/1/07 at 10:25 a.m., Housekeeper #1 was asked if CNAs get disinfectants from her. She stated, "Yes." She was then asked how much they get and she stated, "I put a little bit and the rest is water, about 2 and 1/2 to 3 ounces and</p>	F 441			

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F 441	<p>Continued From page 21 the rest is water in the spray bottle."</p> <p>The Housekeeping Supervisor was asked, on 1/11/07 at 2:25 p.m., if the solutions are pre-mixed and she stated, " Yes, in the dispenser."</p> <p>2. On 11/1/07 at 1:02 p.m., the resident was taken to the 200 Hall Shower Room after being transferred to a pipe shower chair. The resident was bathed, pushed back to her room in the shower chair and had feces on the rectum when she was transferred out of the shower chair.</p> <p>a. On 11/1/07 at 2:04 p.m., CNA #6 returned the shower chair to the Shower Room and sprayed the chair from a bottle containing a pink solution. The right side of the shower chair seat had brown material on the seat. The CNA left the shower room.</p> <p>b. On 11/1/07 at 2:09 p.m., CNA #7 entered the 200 Hall shower room and took the wall sprayer and rinsed the shower seat and chair. The disinfectant was on the shower chair for 5 minutes.</p> <p>c. The manufacturers guidelines for Ecolab Disinfecting Heavy Duty Acid Bathroom Cleaner [pink solution], received from the Housekeeping Supervisor on 11/1/07 at 2:25 p.m., documented, "...Directions For Use... Disinfection and Daily Cleaning: Apply 6.0 to 8.0 Oz. (ounce) ...per gallon of use-solution to hard, nonporous surfaces. Allow a 10 minute contact with the surface. Wipe with damp cloth or sponge. Rinse surface. For Disinfection and Heavy Duty Cleaning: ...Allow a 10-minute contact with the surface. Wipe with damp cloth or sponge. Rinse</p>	F 441			

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F 441	Continued From page 22 surface..." d. On 11/2/07 at 2:10 p.m., the Director of Nursing was asked if there was a policy for cleaning the shower chairs and she stated, "No apparently we don't have one."	F 441		