

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

PRINTED: 10/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/06/2011
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	GOLDEN LIVING CENTER @ ST. MATTHEWS PLAN OF CORRECTION FOR SURVEY EDNING 10/6/2011	
F 241 SS=D	<p>An abbreviated survey was initiated on 10/04/11 and concluded on 10/06/11 to investigate Complaint KY17194. The Division of Health Care substantiated the allegation as verified by the evidence. Federal deficiencies were cited.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy for Resident Rights, it was determined the facility failed to provide resident dignity for one (1) of three (3) sampled residents and one (1) unsampled resident. 1. Wound care was provided to Resident #1 with the door open and without the use of a privacy curtain. 2. Unsampled Resident B, requested assistance to the bathroom and lost control of their bladder while waiting for staff to respond.</p> <p>The findings include:</p> <p>Review of the facility's policy for Residents' Rights, revealed residents were to be treated with consideration, respect, and full recognition of their dignity and individuality, including privacy in treatment and in care for their personal needs. Review of the facility policy for Clean Dressing</p>	F 241	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Golden living @ St. Matthews does not admit that the deficiencies listed on the HCFA 2567 exist nor does the facility admit to any statements, findings, facts or conclusions that form the basis of the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusion that form the basis for the alleged deficiency.</p>	

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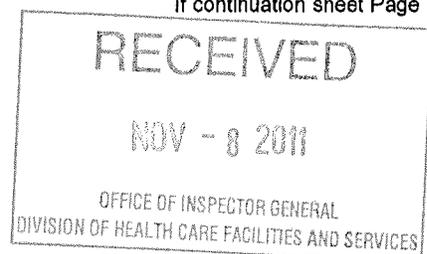
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 11-4-11

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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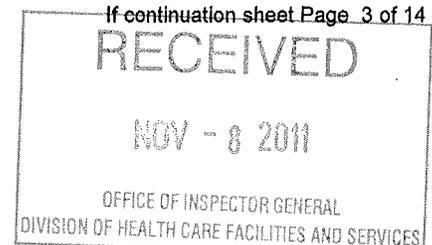
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F 241	<p>Continued From page 1</p> <p>Change, revealed no direction to maintain resident privacy or dignity.</p> <p>Interview, on 10/06/11 at 1:00 PM, with the Director of Nursing (DON) revealed resident privacy should be considered before any treatment or procedure is performed. The DON stated the door should have been closed during the dressing change.</p> <p>1. Record review of the clinical record for Resident #1 revealed a right knee replacement was performed at a regional facility on 06/07/11 which became infected. Resident #1 was admitted to a local hospital on 08/10/11 with an infected right knee, and during that hospitalization the knee replacement hardware was removed and the surrounding tissue was debrided (surgical procedure to remove non-viable tissue), and interavenous antibiotics were started. Resident #1 was admitted to the nursing facility on 09/11/11 for interavenous antibiotics and for a dressing change to the right knee which was performed twice daily. A surgical procedure was planned for Resident #1 to fuse the bones of the right leg on 10/11/11.</p> <p>Observation, on 10/05/11 at 3:50 PM, of wound care for Resident #1 revealed RN #1 performed a clean dressing change of the right knee, without a privacy curtain and with the resident room door open. A staff member walked into the room during the dressing change, then stood at the open door and watched, as the dressing change was completed.</p> <p>Interview, on 10/05/11 at 4:25 PM, with RN #1 revealed he thought the door should have been</p>	F 241	<p>F 241 D</p> <p>1) <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i> RN #1 completed training led by the DNS on Resident Dignity and Privacy on October 14, 2011. Unsampled Resident B was assessed for bowel and bladder assistance required by staff and assistance implemented.</p> <p>2) <i>How will the facility identify other residents having the potential to be affected by the same deficient practice?</i> All residents have the potential to be affected.</p> <p>3) <i>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</i> All staff completed training led by the Social Services on Resident Dignity and Privacy by October 26, 2011. Additionally Nurses and CNAs were in-serviced on answering call lights promptly by October 26, 2011.</p>	



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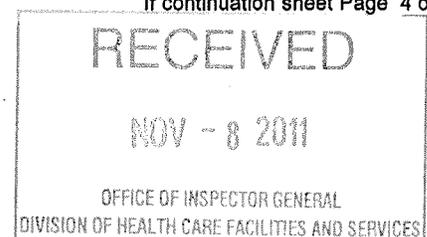
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F 241	<p>Continued From page 2</p> <p>closed before performing the dressing change for Resident #1 to protect the resident's privacy. RN #1 said, "I always forget to do that."</p> <p>Interview, on 10/05/11 at 4:30 PM, with Resident #1 revealed the resident was concerned about the status of the wound with regard to the potential for infection. Resident #1 said the room door usually stays open, and is left open during dressing changes. Resident #1 thought the door should be closed to limit exposure to the wound when the dressing was changed and to protect privacy.</p> <p>2. Interview, on 10/06/11 at 8:30 AM, with Housekeeper #2 revealed she saw Unsampled Resident B sitting on the side of the bed sitting on wet bed linens a couple of weeks ago at about 8:30 AM. Housekeeper #2 said Unsampled Resident B was crying, and the call light for the room was on. Housekeeper #2 said Resident B had called for staff assistance to the bathroom, but staff did not respond and she lost control of her bladder. Housekeeper #2 reported to nursing staff that Unsampled Resident B needed assistance.</p> <p>Interview, on 10/06/11 at 9:45 AM, with Unsampled Resident B revealed staff do not respond promptly when assistance was requested to the bathroom. Unsampled Resident B reported loss of bladder control while waiting for staff assistance to the bathroom on "several occasions." Unsampled Resident B stated they put the call light on as soon as they wake up each morning because of an urgent need to go to the bathroom upon rising and said, sometimes they (staff) come, sometimes they don't; they just don't</p>	F 241	<p>4) How will the facility monitor its performance to ensure that solutions are sustained?</p> <p>Dignity Audits using the Dignity Program Care Audit tool will be conducted by Social Services once weekly for 4 weeks (will cover 5 random residents), then monthly for 3 months, then quarterly thereafter. Findings will be reported monthly to the facility QAA committee for review for 4 months and then quarterly thereafter.</p> <p>Date: October 28, 2011</p>	



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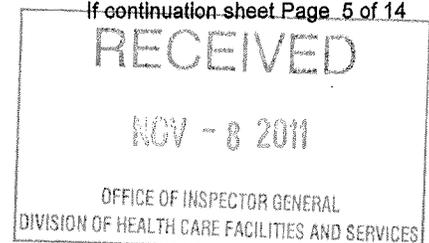
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F 241	Continued From page 3 care.	F 241		
F 281 SS=D	<p>Interview, on 10/06/11 at 1:00 PM, with the DON revealed that she was aware of resident complaints regarding delays in call light response.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to assess one (1) unsampled resident prior to administering a narcotic for pain. A narcotic audit of Medication Cart #2 on the North Unit, at 11:00 AM on 10/05/11, revealed one (1) narcotic analgesic tablet (for pain) was signed out for a resident at 8:00 AM on 10/05/11; however was provided to the unsampled resident three (3) hours later without an assessment of the resident's pain.</p> <p>The findings include:</p> <p>2. Review of the facility's policies for Medication Administration General Guidelines revealed medications were to be administered at the time they are prepared. When as needed medications are administered, complaints or symptoms for which the medications was given would be documented. Observation of the resident for medication actions/reactions should be recorded in the nurses notes. The Medication</p>	F 281	<p>F 281 D</p> <p><i>1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i> RN #3 completed training led by the DNS on the Medication Administration Controlled Substances policy and the Medication Administration General Guidelines policy on October 12, 2011.</p> <p><i>2) How will the facility identify other residents having the potential to be affected by the same deficient practice?</i> All residents have the potential to be affected.</p> <p><i>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</i> All Nurses completed training led by the DNS and Unit Mangers on Medication Administration Controlled Substances policy and Medication Administration General Guidelines policy by October 26, 2011.</p>	



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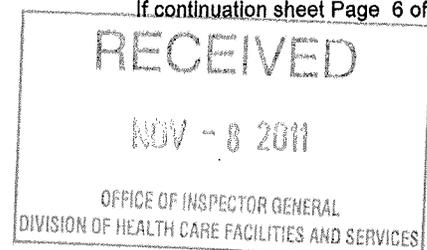
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F 281	<p>Continued From page 4</p> <p>Administration policy of Controlled Substances revealed controlled substance record keeping at the nursing care center, would be in accordance with federal and state laws and regulations. The policy stated controlled substances were administered after appropriate documentation on the accountability record and administered when the dose was removed from the container.</p> <p>Observation, on 10/05/11 at 11:00 AM, of the narcotic count on Medication Cart #2, with the Unit Coordinator revealed the actual count for Vicodin 5mg/500mg was thirty-two (32) tablets and the recorded count was thirty-one (31) tablets. The narcotic record showed RN #3 signed out one (1) Vicodin 5mg/500mg tablet for an Unsampled Resident on 10/05/11 at 8:00 AM.</p> <p>Interview, on 10/05/11 at 11:15 AM, with RN #3 revealed that the Unsampled Resident took Vicodin for back pain as needed. RN #3 said the Unsampled Resident always requested the Vicodin with the morning medication pass, therefore RN #3 signed out a Vicodin. RN #3 stated she forgot to punch one out for the resident.</p> <p>Observation, on 10/05/11 at 11:18 AM, of RN #3 revealed the nurse removed one (1) Vicodin tablet and administered the medication to the Unsampled Resident.</p> <p>Interview, on 10/05/11 at 11:40 AM, with the Unit Coordinator revealed the Vicodin tablet should have been administered when it was signed out at 8:00 AM. The Unit Coordinator said the medication was overlooked. The Unit Coordinator stated that staff were trained to</p>	F 281	<p>4) How will the facility monitor its performance to ensure that solutions are sustained? Medication Administration 3 Competency Checklist audit will be conducted by the DNS and Unit Mangers for 3 Nurses weekly for 4 weeks, then monthly for 3 months, then quarterly thereafter. Findings will be reported monthly to the facility QAA committee for review for 4 months and then quarterly thereafter.</p> <p>Date: October 28, 2011</p>	



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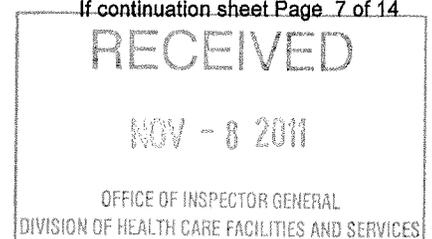
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F 281	Continued From page 5 evaluate pain first, then administer the pain medication and reevaluate the resident's pain level. The Unit Coordinator said the Unsampled Resident should have been evaluated for pain before the Vicodin was given at 11:40 AM. Interview, on 10/05/11 at 3:45 PM, with RN #3 revealed she should have evaluated the Unsampled Resident for pain before the Vicodin was given at 11:18 AM on 10/05/11. Interview, on 10/06/11 at 1:00 PM, with the DON revealed staff were trained to evaluate pain prior to administration of pain medications. The DON stated the Unsampled Resident should have been evaluated for pain before the Vicodin was administered.	F 281		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431		



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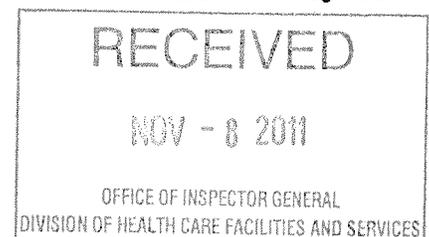
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F 431	Continued From page 6 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policies for Storage of Medication and Medication Administration of Controlled Substances, it was found the facility failed to store drugs labeled in accordance with currently accepted professional standards, and failed to maintain a system to account for the receipt, usage, disposition, and reconciliation of all controlled medications for three (3) of three med carts on the North Unit. 1. An audit of Medication Cart #1, #2, and #3 on the North Unit, revealed multiple medications which were not dated when opened, one (1) medication stored without a pharmacy label, and one (1) medication stored for a resident which was discharged. 2. A narcotic audit of Medication Cart #2 on the North Unit, at 11:00 AM on 10/05/11, revealed one (1) narcotic analgesic tablet (for pain) was signed out for a resident at 8:00 AM on 10/05/11, that had not been provided to the resident.	F 431	F 431 D <i>1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i> All med carts were audited by the Unit Managers by October 26, 2011. Any issues identified were corrected at the time they were identified. <i>2) How will the facility identify other residents having the potential to be affected by the same deficient practice?</i> All residents have the potential to be affected. <i>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</i> All Nurses completed training led by the DNS or designee on the Medication Storage, Storage of Medication policy; Discontinued Medications policy; and Medications with Special Expiration Date Requirements policy by October 26, 2011.	



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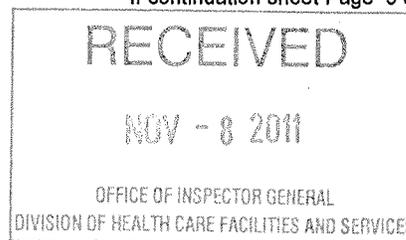
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F 431	<p>Continued From page 7</p> <p>The findings include:</p> <p>1. Review of the facility's policy for Storage of Medications revealed medications and biologicals were to be stored properly, in containers that meet legal requirements, with proper labeling, and medications which have been discontinued were to be removed from stock.</p> <p>Interview, on 10/06/11 at 1:00 PM, with the Director of Nursing (DON) revealed all medications were labeled with the date opened to ensure effectiveness of the medication. The DON stated that medications were removed from the medication cart upon discharge of the resident. The DON stated that all resident medications should be labeled with a pharmacy label.</p> <p>Observation, on 10/05/11 at 10:40 AM, of Medication Cart #1 with the Unit Coordinator revealed three (3) medications were not dated when opened. Observation, on 10/05/11 at 11:00 AM, of Medication Cart #2 with the Unit Coordinator revealed five (5) medications which were not dated when opened, one (1) medication which did not have a pharmacy label, and one (1) medication stored for a resident who was discharged. Observation on 10/05/11 at 11:20 AM, of Medication Cart #3 with the Unit Coordinator revealed nine (9) medications which were not dated when opened.</p> <p>Interview, on 10/05/11 at 11:45 AM, with the Unit Coordinator revealed staff were trained to date all medications when opened. The Unit Coordinator stated night shift was responsible to audit the</p>	F 431	<p>4) How will the facility monitor its performance to ensure that solutions are sustained? 3 Medication Carts will be audited using the Medication Cart Audit Tool by the DNS and Unit Mangers weekly for 4 weeks, then monthly for 3 months, then quarterly thereafter. Findings will be reported monthly to the facility QAA committee for review for 4 months and then quarterly thereafter.</p> <p>Date: October 28, 2011</p>	



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F 431	<p>Continued From page 8</p> <p>medication carts, but was not certain how often the carts were audited and did not know when the carts were audited last.</p> <p>2. Review of the facility policy for Medication Administration of Controlled Substances revealed controlled substances were subject to special handling, storage, disposal, and record keeping at the nursing care center, in accordance with federal and state laws and regulations. The policy stated controlled substances were administered after appropriate documentation on the accountability record.</p> <p>Observation, on 10/05/11 at 11:00 AM, of the narcotic count on Medication Cart #2, with the Unit Coordinator revealed the actual count for Vicoden 5mg/500mg was thirty-two (32) tablets and the recorded count was thirty-one (31) tablets. The narcotic record showed RN #3 signed out one (1) Vicoden 5mg/500mg tablet for an Unsampled Resident on 10/05/11 at 8:00 AM.</p> <p>Interview, on 10/05/11 at 11:15 AM, with RN #3 revealed the Unsampled Resident took Vicoden for back pain as needed. RN #3 said the Unsampled Resident always requested the Vicoden with the morning medication pass, therefore RN #3 signed out a Vicoden. RN #3 said, I forgot to punch one out for him/her.</p> <p>Observation, on 10/05/11 at 11:18 AM, of RN #3 revealed the nurse removed one (1) Vicoden tablet and administered the medication to the Unsampled Resident.</p> <p>Interview, on 10/05/11 at 11:40 AM, with the Unit Coordinator revealed the Vicoden tablet should</p>	F 431		



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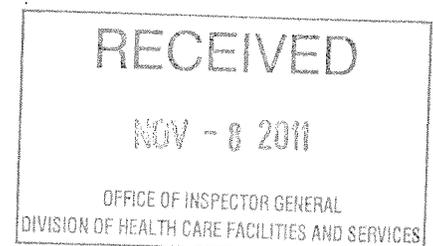
F 431	Continued From page 9 have been administered when it was signed out at 8:00 AM. The Unit Coordinator said the medication was overlooked.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide 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	F 441	F 441 F <i>1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i> The identified Housekeeping staff member was in-serviced on use of gloves during cleaning of body fluids by the District Manager of Housekeeping on October 7, 2011. The 3 rooms identified, 124, 127, and 316 were checked and cleaned. <i>2) How will the facility identify other residents having the potential to be affected by the same deficient practice?</i> All residents have the potential to be affected <i>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</i> Infection control training was conducted by the DNS and Unit Managers to the facility staff to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection, completed by October 26, 2011.	

<p>RECEIVED</p> <p>NOV - 8 2011</p> <p>OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES AND SERVICES</p>
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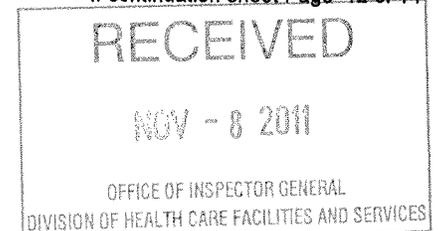
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/06/2011	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS		STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 10 transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy for Exposure Control, it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe and sanitary environment, and to help prevent the development and transmission of disease and infection. 1. One (1) Housekeeping Staff member was observed to wipe and clean body fluids without the use of gloves. 2. Stool was reported to be found in two (2) of nineteen (19) sinks on the 100 hall (Room 124 and 127) and one (1) of ten (10) sinks on the 300 hall (Room 316) by three (3) Housekeeping staff members which was not reported to Administration as an infection control concern.</p> <p>The findings include:</p> <p>Record Review of the facility policy for Bloodborne Pathogens Exposure Control Plan revealed that body and blood fluids were treated as potentially hazardous per the OSHA Bloodborne Pathogen Standard definitions. The policy stated urine and feces must be flushed directly down the toilet.</p> <p>Interview, on 10/06/11 at 1:00 PM, with the Director of Nursing (DON) revealed that Nursing was responsible to clean blood and body fluid</p>	F 441	<p><i>4) How will the facility monitor its performance to ensure that solutions are sustained?</i> An audit of infection control practices will be conducted using the Monitoring Compliance with Infection Control Checklist completed by the Director of Clinical Education and Unit Managers once weekly for 4 weeks (includes each unit), then monthly for 3 months, then quarterly thereafter. Findings will be reported monthly to the facility QAA committee for review for 4 months and then quarterly thereafter.</p> <p>Date: October 28, 2011</p>	



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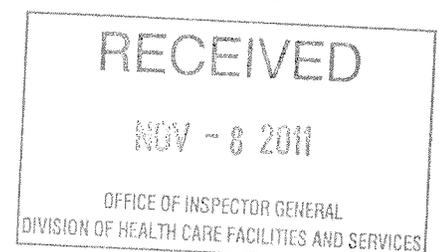
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F 441	<p>Continued From page 11</p> <p>spills. Housekeeping was responsible for disinfection of the area after the spill was cleaned.</p> <p>1. Observation, on 10/06/11 at 8:45 AM, revealed an Unsampled Resident was spitting into a clear plastic cup and complained of gastric reflux symptoms during a medication pass performed by RN #5. The cup was half-full of thick beige body fluid when the Unsampled Resident spilled the cup onto the bedside table. RN #5 placed a folded towel on the spill to contain the spill until the medication pass was completed. RN #5 found the Director of Housekeeping (DOH) in the hall, and asked him to clean the spill on the bedside table. The DOH cleaned and wiped the spill with the towel which had been placed on top of the spill without the use of gloves.</p> <p>Interview, on 10/06/11 at 10:15 AM, with the DOH revealed when RN #5 asked him to clean the spill on the bedside table, he thought the resident had spilled some melted ice cream since it was in a drinking cup. The DOH did not know the spill was body fluids, and said he would have worn gloves if he had known it was body fluids. The DOH said Nursing was responsible to clear away blood and body fluids, then Housekeeping provided disinfection of the surface or area, and said RN #5 should have told him the spill was body fluids. The DOH said the best practice would be to wear gloves while working in the resident rooms since it was difficult to identify body fluids.</p> <p>Interview, on 10/06/11 at 12:50 PM, with RN #5 revealed she did not notice the DOH cleaned the spill without the use of gloves. RN #5 stated she should have told the DOH the spill was body</p>	F 441		



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F 441	<p>Continued From page 12</p> <p>fluids, and reminded him to wear gloves because the spill of body fluid was a potential contamination source.</p> <p>Continued interview with the DON revealed RN #5 should have cleaned the body fluids from the bedside table, and then asked Housekeeping to disinfect the area.</p> <p>2. Interview, on 10/06/11 at 8:30 AM, with Housekeeper #2 revealed she found a dirty bedpan in a resident's sink with stool in the sink last week. Housekeeper #2 stated stool was also seen in another resident sink. Housekeeper #1 said all of the incidents of stool in resident sinks were reported to the DOH.</p> <p>Interview, on 10/06/11 at 9:00 AM, with Housekeeper #1 revealed she found stool in a resident sink one month ago and showed it to the DOH, who told her to report any further instances of stool in resident sinks to him.</p> <p>Interview, on 10/06/11 at 10:15 AM, with the DOH revealed he was told by housekeepers that stool was found in resident sinks. The DOH said he saw stool in a resident sink which was reported to him by a housekeeper last month. The DOH said the stool was in pieces and said the nursing staff must have emptied the bedpan into the sink based on his observation. The DOH said he spoke with the nurse (uncertain of the nurse's name) responsible for the resident, and explained it was unacceptable to empty a bedpan into the sink and asked the nurse to advise the Certified Nursing Assistant (CNA) to refrain from emptying bedpans into the sink, in an attempt to ensure this did not occur again. The DOH told the</p>	F 441		



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F 441	<p>Continued From page 13</p> <p>housekeeping staff to report any further incidents of stool in the sink to him. The DOH stated the incidents of stool in resident sinks was an infection control problem. The DOH said he did not discuss the infection control concerns with the Administrator or the DON.</p> <p>Interview, on 10/06/11 at 1:00 PM, with the DON revealed she did not know stool was found by Housekeeping in resident sinks, and stated that this should have been reported at the morning meeting. The DON said she is responsible for Infection Control at the facility and should have been advised of stool in resident sinks when it was first identified.</p> <p>Interview, on 10/06/11 at 2:35 PM, with the Administrator revealed he was not aware of stool found in resident sinks by Housekeeping. The Administrator said the DOH should have reported the finding to Administration when the first incident occurred.</p>	F 441		

