

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2012
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NAME OF PROVIDER OR SUPPLIER BLEDSOE COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367
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(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 155 SS=D	<p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to respect the resident's right to refuse treatment for one resident (#38) of twenty-four residents reviewed.</p> <p>The findings included:</p> <p>Resident #38 was admitted to the facility on September 11, 2009, with diagnoses including Urosepsis and Diabetes Mellitus.</p> <p>Review of the Quarterly Minimum Data Set dated June 20, 2012, revealed the resident had no cognitive impairment and was totally dependent on staff for toileting and bathing.</p> <p>Medical record review of the Care Plan dated September 25, 2009, and updated quarterly revealed, "...Resident is extensive to total dependent for all ADL's (Activities of Daily Living)... Verbally prompt resident to perform self-care and make choices as much as possible..."</p> <p>Medical record review of the Licensed Nurses Notes dated July 10, 2012, revealed, "...Was informed by CNAs that resident had refused to</p>	F 155	<p>F_155</p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>Staff (nurses, c.n.a.'s,) were instructed to respect the Rights of a resident to refuse to be weighed.</p> <p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>All resident's charts were reviewed by the DON, Social Services Director and MDS Coordinator for potential residents, no other residents were found to be affected.</p>	11/19/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Stephanie Bryant</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10/17/12</i>
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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 155 SS=D	<p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to respect the resident's right to refuse treatment for one resident (#38) of twenty-four residents reviewed.</p> <p>The findings included: Resident #38 was admitted to the facility on September 11, 2009, with diagnoses including Urosepsis and Diabetes Mellitus.</p> <p>Review of the Quarterly Minimum Data Set dated June 20, 2012, revealed the resident had no cognitive impairment and was totally dependent on staff for toileting and bathing.</p> <p>Medical record review of the Care Plan dated September 25, 2009, and updated quarterly revealed, "...Resident is extensive to total dependent for all ADL's (Activities of Daily Living)...Verbally prompt resident to perform self-care and make choices as much as possible..."</p> <p>Medical record review of the Licensed Nurses Notes dated July 10, 2012, revealed, "...Was informed by CNAs that resident had refused to</p>	F 155	<p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>Inservice to nursing home staff by the DON on 10/18/12: Will review resident rights and discuss resident's refusal to be weighed will be granted. Will continue with Resident Rights Bingo during annual updates and orientation for employees.</p> <p>Staff who cannot attend inservice will have 1:1 instructions by the DON</p> <p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>C.N.A.'s will inform the Charge Nurse of any resident's refusal to be weighed and it will be documented in the resident's chart. The DON</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Stephanie Bryant</i>	TITLE <i>Administrator</i>	(X8) DATE <i>10/17/12</i>
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F 155	Continued From page 1 weighed (sp) for the month...After speaking (with) social services and care plan coordinator this charge nurse and another charge nurse informed resident that (resident) couldn't refuse to be weighed..."	F 155	will monitor all refusals and re-assure staff of legalities of refusals. DON will review the chart of any refusals for reasons, etc. Results will be taken and reported to QA. Will monitor and report for 6 months.	
F 167 SS=C	<p>Interview with the Director of Nursing (DON) on September 25, 2012, at 1:30 p.m., in the Chapel, confirmed the facility told the resident the resident could not refuse to be weighed and the facility had failed to respect the resident's right to refuse.</p> <p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure state survey results were readily accessible for all residents.</p> <p>The findings included: Observation on September 25, 2012, at 11:00 a.m., in the hallway near the nurse's station, revealed the state survey results were in a notebook located in a plastic container attached</p>	F 167	<p>F 167</p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>The survey results were copied, placed in a binder and placed in the lobby at a level accessible to wheelchair occupants.</p> <p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>DON, Social Services Director, Administrator and MDS Coordinator have observed residents</p>	11/10/12

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<p>F 155</p> <p>F 167 SS=C</p>	<p>Continued From page 1</p> <p>weighed (sp) for the month...After speaking (with) social services and care plan coordinator this charge nurse and another charge nurse informed resident that (resident) couldn't refuse to be weighed..."</p> <p>Interview with the Director of Nursing (DON) on September 25, 2012, at 1:30 p.m., in the Chapel, confirmed the facility told the resident the resident could not refuse to be weighed and the facility had failed to respect the resident's right to refuse.</p> <p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure state survey results were readily accessible for all residents.</p> <p>The findings included:</p> <p>Observation on September 25, 2012, at 11:00 a.m., in the hallway near the nurse's station, revealed the state survey results were in a notebook located in a plastic container attached</p>	<p>F 155</p> <p>F 167</p> <p>F 167</p>	<p><i>Continued -</i></p> <p>in wheelchairs to see if they are able to obtain the survey results, no other resident has been affected.</p> <p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>The DON will conduct an inservice 10/18/12 regarding the survey results including maintaining accessibility of the survey results for wheelchair occupants. Inservice consisted of Nurses, C.N.A.'s, housekeeping, activity staff, maintenance and social services staff.</p> <p>Staff who cannot attend inservice will have 1:1 instructions by the DON</p> <p><i>Continued</i></p>	
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F 167	Continued From page 2 to the wall approximately five feet from ground level. Further observation revealed the results were not accessible to any residents who were confined to a wheelchair without asking for assistance from staff.	F 167	4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? The DON and the Administrator will monitor (observe/look) for proper placement of the survey results ensuring that are at a level accessible to wheelchair occupants. Will report any variances to QA quarterly.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to complete a pre-restraining assessment prior to applying a restraint for two residents (#13, #35) of four residents reviewed. The findings included: Resident #13 was admitted to the facility on May 19, 2009, with diagnoses including Diabetes Mellitus, Hypertension, Congestive Heart Failure, and Mental Retardation. Medical record review of the annual Minimum Data Set (MDS) dated May 30, 2012, revealed the resident had severe cognitive impairment,	F 221	F 221 1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE? Resident #13: A "Pre-restraining" Assessment was completed by the charge on 10/11/12 to reflect resident's current ability and the need for a truck restraint. Resident #35: An additional "Side rail Assessment" was completed by the charge nurse on 10/11/12 to reflect the need for additional side rails on 9/24/12.	11/10/12 <i>Continued</i>

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F 221	<p>Continued From page 3 required supervision for transfers, required limited assistance for Activities of Daily Living (ADL's), and no restraint use.</p> <p>Medical record review of the quarterly MDS dated August 29, 2012, revealed the resident used a trunk restraint daily.</p> <p>Review of facility policy, Restraints (physical), no date, revealed "...assess resident's need for restraint use...list medical symptoms to be treated and methods to reduce and eliminate restraint..."</p> <p>Medical record review revealed no pre-restraining assessment had been completed.</p> <p>Observation on September 24, 2012, at 10:13 a.m., in the dining room, revealed the resident sitting in a wheelchair with an econo-belt (safety belt restraint) in use.</p> <p>Interview with the MDS Coordinator on September 25, 2012, at 8:23 a.m., in the nurse's station, confirmed the facility failed to complete a pre-restraining assessment prior to placing a restraint for resident #13.</p> <p>Resident #35 was admitted to the facility on January 4, 2011, with diagnoses including Peripheral Vascular Disease, Hyperlipidemia, and Malnutrition.</p> <p>Medical record review of the side rail assessment with no date revealed a recommendation of no side rails to be used.</p> <p>Observation on September 24, 2012, at 2:55 p.m., in the resident's room, revealed the resident</p>	F 221	<p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>All resident's charts were reviewed by the DON (with particular attention to residents restrained), for completeness of a "Pre-restraining" Assessment. No other residents were found to be affected. This was completed by 10/12/12</p> <p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>Inservice (to nurses) will be conduct by the DON on 10/18/12; will review the admission process, restraint policy and "Pre-restraining" Assessment and Side Rail Assessment.</p> <p>Staff (nursing staff) who cannot attend inservice will have 1:1 instructions by the DON</p> <p style="text-align: right;"><i>Continued</i></p>	

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F 221	<p>Continued From page 4</p> <p>lying in bed with two half side rails at the head of the bed in the raised position, and one half side rail at the foot of the bed on the left side in the raised position. Further observation revealed the over bed table at the right side foot of bed extended over the bed.</p> <p>Observation in the resident's room with the Director of Nursing (DON) on September 24, 2012, at 3:10 p.m., revealed the resident had three side rails in the raised position.</p> <p>Interview with the DON on September 25, 2012 at 3:05 p.m., at the Nurse's station, confirmed the side rail assessment recommended no side rails.</p> <p>Observation on Sept 26, 2012, at 8:05 a.m., revealed two upper side rails in the raised position with the resident lying in bed with eyes closed.</p> <p>Interview with Licensed Practical Nurse #1 (LPN #1) on September 26, 2012, at 8:30 a.m., in the resident's room, confirmed the two upper side rails were in a raised position and the assessment stated no side rails.</p> <p>Interview with LPN #1 on September 26, 2012 at 10:40 a.m., in the resident's room, confirmed when the three rails are in a raised position with the over the bed table over the bed the resident was restricted from getting out of bed.</p>	F 221	<p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>The DON will review all new admission's charts for the completeness of "Pre-restraining Assessment" and the "Side Rail Assessment" Results will be taken to QA quarterly for 6 months.</p>	
F 241 SS=E	<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</p>	F 241		

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F 241	<p>Continued From page 5 full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to maintain resident dignity for two residents (#42, #30) during a dressing change and three residents (#2, #29, #43) during an accucheck, of twenty-four sampled residents.</p> <p>The findings included:</p> <p>Resident #42 was admitted to the facility on June 7, 2010, and readmitted on September 13, 2012, with diagnoses including Multiple Trauma, Osteomyelitis, and Ischial Wounds.</p> <p>Observation on September 25, 2012, at 1:40 p.m., in the resident's room, revealed Licensed Practical Nurse (LPN) #3 in the process of a dressing change to the resident's buttocks. Continued observation at this time revealed LPN #2 knocked on the door, entered the room, the privacy curtain was not pulled, the resident's buttocks was visible, and LPN #2 administered the resident's medications during the dressing change.</p> <p>Interview on September 25, 2012, at 3:15 p.m., in the medication room, confirmed not pulling the privacy curtain, and administering medications during a dressing change did not promote the resident's dignity and privacy.</p> <p>Resident #30 was admitted to the facility on July 12, 2012, with diagnoses including Cerebral</p>	F 241	<p>F 241</p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>Residents # 42 and #30: The door was closed and the privacy curtain was pulled during the next dressing change. Also, no medications were administered during dressing changes.</p> <p>Residents # 2; #29; #43: During the next accu-check these residents were taken to the library for privacy and were stuck prior to meal tray being served.</p> <p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>Observations of finger sticks and dressing changes were conducted by the DON for the daily next week, no other resident was affected.</p>	11/10/12
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F 241	<p>Continued From page 6 Vascular Accident, Dementia, and Atrial Fibrillation.</p> <p>Medical record review of the quarterly Minimum Data Set, dated July 25, 2012, revealed the resident scored a 13 on the Brief Interview for Mental Status indicating the resident was cognitively intact and required limited assistance with activities of daily living.</p> <p>Observation on September 25, 2012, at 3:00 p.m., in the resident's room, revealed LPN #4, changing the resident's dressing to the left heel. Continued observation revealed the nurse failed to close the resident's door prior to beginning the dressing change.</p> <p>Interview with LPN #4 on September 25, 2012, at 3:10 p.m., outside the resident's room, confirmed the LPN failed to close the resident's door prior to beginning the dressing change.</p> <p>Resident #2 was admitted to the facility on August 9, 2010, with diagnosis of Diabetes Mellitus.</p> <p>Observation on September 25, 2012, at 11:18 a.m., in the dining room, revealed the resident eating lunch. Further observation at this time revealed a LPN removed the resident from the dining room and took the resident to the hallway for LPN #3 to perform an accucheck.</p> <p>Resident #29 was admitted to the facility on November 14, 2008, with diagnoses including Diabetes Mellitus, Hypertension, Seizure Disorder, and Mental Retardation.</p> <p>Observation on September 25, 2012, at 11:15</p>	F 241	<p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>Inservice (to nurses) will be conducted on 10/18/12 by the DON. Privacy and Dignity during dressing changes as well as during accu-checks will be discussed and staff will be informed to take resident(s) to the library or to their room to perform accu-checks 15-30 minutes prior to meals. If the resident(s) is already in the dining room, they will be removed from the public and taken to a private room to be stuck first before resident(s) in the room.</p> <p>Staff (nurses) who cannot attend inservice will have 1:1 instructions by the DON</p>	
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F 241	Continued From page 7 a.m., in the dining room, revealed the resident eating lunch. Further observation at this time revealed a LPN removed the resident from the dining room and took the resident to the hallway for LPN #3 to perform an accucheck and administer insulin. Resident #43 was admitted to the facility on June 29, 2012, with diagnoses including, Diabetes Mellitus, Paralysis, Dysphagia, and Aphasia. Observation on September 25, 2012, at 11:20 a.m., in the dining room, revealed the resident eating lunch. Further observation at this time revealed a LPN removed the resident from the dining room and took the resident to the hallway for LPN #3 to perform an accucheck and administer insulin. Interview on September 25, 2012, at 11:30 a.m., with LPN #3, in the hallway, confirmed removing the residents (#2, #29, #43) while eating to perform an accucheck and administer insulin to (#2, #29, #43), in the hallway, did not promote the resident's dignity.	F 241	4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? The DON (or assigned substitute) will monitor (observation) for compliance during dressing changes and accu-checks, weekly for 6 months and report to QA quarterly.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced	F 246	F 246 1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE? Resident #3 and resident # 24: The call light was properly attached to the bed within reach of the resident.	11/10/12

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2012
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NAME OF PROVIDER OR SUPPLIER BLEDSOE COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367
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(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
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F 246 Continued From page 8
by:
Based on medical record review, observation, and interview, the facility failed to ensure the call light was in reach for two residents (#3, #24) of twenty-four residents reviewed.

The findings included:

Resident #3 was admitted to the facility on June 28, 2011, with diagnoses including Dementia, Hypertension, Osteoarthritis, and Alzheimers Disease.

Medical record review of the Annual Minimum Data Set (MDS) dated July 11, 2012, revealed the resident had severely impaired cognition, and required limited to extensive assistance with all activities of daily living (ADLs).

Medical record review of the care plan updated September 19, 2011, revealed, "...fall from standing position. Potential for further falls...keep call light in reach at all times when in room..."

Observation on September 23, 2012, at 3:00 p.m., in the resident's room, revealed the resident was lying in bed and the call light was dangling below the bed, in between the mattress and the side rails, out of reach for the resident.

Interview with the resident on September 23, 2012, at 3:00 p.m., in the resident's room, revealed the resident, when asked, stated the call light was used to call for help.

Interview with Certified Nursing Assistant (CNA) #7 on September 23, 2012, at 3:00 p.m., in the resident's room, confirmed the call light was out

F 246

2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?

The DON performed observation rounds weekly for approp. placement of call lights. During observation periods no other call lights were found to be out of reach.

3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?

Inservice will be conducted by the DON 10/18/12. Staff will be instructed on proper placement of call lights in bed as well as when in a chair in the room. (Staff inserviced were: Nurses, c.n.a.s, housekeeping, activities and social services)

Staff who cannot attend inservice will have 1:1 instructions by the DON

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NAME OF PROVIDER OR SUPPLIER BLEDSOE COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367
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(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 248	<p>Continued From page 9</p> <p>of reach, and the resident was capable of using the call light to call for assistance.</p> <p>Resident #24 was admitted to the facility on May 14, 2010, with diagnoses including Hypertension, Osteoarthritis, Anemia, Edema, and Depression.</p> <p>Medical record review of the Quarterly MDS dated July 25, 2012, revealed the resident had severely impaired cognition, and was totally dependent on staff for all ADLs.</p> <p>Medical record review of the care plan updated on August 24, 2011, revealed, "...at risk for fall/injury...keep call light in reach at all times when in room..."</p> <p>Observation on September 23, 2012, at 3:00 p.m., in the resident's room, revealed the resident was lying in bed, with the call light wedged between the padding on the side rail and the side rail, not visible to the resident, and out of reach for the resident.</p> <p>Interview with the resident on September 23, 2012, at 3:00 p.m., in the resident's room, revealed the resident when asked, stated the call light was used to call for help.</p> <p>Interview with CNA #7 on September 23, 2012, at 3:00 p.m., in the resident's room confirmed the call light was out of reach, and the resident was capable of using the call light to call for assistance.</p>	F 248	<p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>The DON (or assigned substitute) will conduct rounds at least weekly for 6 months, at various times, to ensure compliance. Results will be reported to QA quarterly.</p>	
F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the</p>	F 278		

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

44E232

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____
B. WING _____

(X3) DATE SURVEY COMPLETED

09/26/2012

NAME OF PROVIDER OR SUPPLIER

BLEDSOE COUNTY NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
**107 WHEELERTOWN AVENUE
PIKEVILLE, TN 37367**

(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 278	<p>Continued From page 10 resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) for two residents (#52, #49) of twenty-four residents reviewed.</p> <p>The findings included: Resident #52 was admitted to the facility on May</p>	F 278	<p><u>F 278</u></p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>Resident #52: The MDS Coordinator completed a modification on the care plan to reflect accurate weight on 10-11-12</p> <p>Resident #49: The MDS Coordinator completed an MDS modification on 9/26/12 to reflect the correct date.</p> <p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>All MDS assessments were reviewed by the DON and MDS coordinator, no other resident was found to be affected.</p>	11/10/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2012
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NAME OF PROVIDER OR SUPPLIER BLEDSOE COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367
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F 278	<p>Continued From page 11</p> <p>23, 2012, with diagnoses including Cerebral Vascular Accident and Hypertension.</p> <p>Medical record review of the MDS dated September 14, 2012, revealed the resident was cognitively intact and had no weight loss.</p> <p>Medical record review of the Care Plan dated September 4, 2012, revealed "...res (resident) > (greater than) 5% wt. (weight) loss in 3 months..."</p> <p>Interview with the MDS Coordinator on September 25, 2012, at 4:01 p.m., in the Nurse's station, confirmed the MDS was inaccurate and did not reflect the resident's weight loss. Resident #49 was admitted to the facility on April 2, 2012, with diagnoses including Hypertension, Gastroesophageal Reflux Disease, Cerebrovascular Accident, Arthritis, and Depression.</p> <p>Medical record review of the MDS dated April 13, 2012, revealed an admission date of April 13, 2012. Continued medical record review of an admission Nurse's Note dated April 2, 2012, revealed the resident was admitted to the facility on April 2, 2012.</p> <p>Interview with the MDS Coordinator on September 25, 2012, at 12:00 p.m., in the MDS Coordinator's office confirmed the MDS admission date was incorrect.</p>	F 278	<p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>1:1 discussion with the MDS Coordinator by the DON on 10-11-12 regarding accurate modifications and revisions.</p> <p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>The Care plan team (MDS coordinator, social services, activities, dietary) as well as the DON will monitor each MDS and care plan for accurate information and appropriate dates, for 6 months. Results will be reported to QA quarterly.</p>	
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p>	F 279		

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NAME OF PROVIDER OR SUPPLIER BLEDSOE COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367
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F 279	<p>Continued From page 12</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to develop a comprehensive care plan for two residents (#31, #52) of twenty-four resident's reviewed.</p> <p>The findings included:</p> <p>Resident #31 was admitted to the facility on October 22, 2011 with diagnoses including Diabetes Mellitus Type 2, Hypertension, Osteoarthritis, Insomnia, Hearing Loss, Hypothyroidism, Advanced Dementia and Alzheimer's Disease.</p> <p>Medical review of the quarterly Minimum Data Set (MDS), dated July 5, 2012, revealed the resident was severely cognitively impaired and required</p>	F 279	<p>F 279</p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>Resident #31 will have another activity assessment conducted to determine those activities that are appropriate and what adaptations if any would be needed. Family will be consulted regarding the types of activities they want to see their mother involved in.</p> <p>Resident #52 will have another activity assessment completed to determine if there are activities of interest that can be incorporated into his plan of care.</p>	11/10/12
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

44E232

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____
B. WING _____

(X3) DATE SURVEY COMPLETED

09/26/2012

NAME OF PROVIDER OR SUPPLIER

BLEDSOE COUNTY NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
**107 WHEELERTOWN AVENUE
PIKEVILLE, TN 37367**

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F 279	<p>Continued From page 13</p> <p>extensive assistance with activities of daily living.</p> <p>Medical record review of the resident's care plan revealed no documentation or care planning for the resident's activity.</p> <p>Observation on September 24, 2012, at 3:46 p.m., revealed the resident in the dining room sitting in a geri-chair and asleep. Further observation on September 26, 2012, at 9:00 a.m., revealed the resident lying in the bed with bilateral side rails in the up position.</p> <p>Interview with Certified Nurse Assistant (CNA) #4, on September 26, 2012, at 8:45 a.m., in the A wing hallway, revealed, "...gets up every day and the resident goes to the dining room but does not participate in the activities...just watches and eats snacks..."</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on September 26, 2012, at 8:50 a.m., the A Wing Hallway, revealed, "...resident goes to some activities but does not participate...attends church service but does not actively participate..."</p> <p>Interview with the Activities Coordinator on September 26, 2012, at 9:30 a.m., in the dining room, revealed, "...does not attend activities...sometimes will play with the noodle ball and attends church services..."</p> <p>Interview with the MDS Coordinator on September 24, 2012, at 4:00 p.m., in the nurses station, confirmed the resident's care plan did not address the resident's activities. Further interview revealed the "...resident's family wants the resident involved in the activities..."</p>
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F 279	<p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>Activities are monitored on a daily basis. Residents whose activity level shows a decline without a medical reason, will be re-assessed to determine if other activities would be more appropriate.</p> <p>All residents will be reviewed quarterly to ensure the highest practicable level of physical, mental and psychosocial well-being are being met with in activities, with respect to the resident's individual preferences.</p> <p>Daily activity sheets have been reviewed by activities director and determined no other residents were affected.</p>	
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NAME OF PROVIDER OR SUPPLIER BLEDSOE COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367
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F 279 Continued From page 14

Resident #52 was admitted to the facility on May 23, 2012, with diagnoses including Cerebral Vascular Accident and Hypertension.

Medical record review of the activity assessment dated May 23, 2012, revealed the resident had been a "loner" before admission to the facility and preferred not to attend activities.

Medical record review of the Social Service notes dated September 4, 2012, revealed the resident desired to return to a private residence and preferred to relocate closer to family.

Medical record review of the Comprehensive Care Plan dated September 4, 2012, revealed no documentation of measurable goals or interventions for activities or community discharge.

Observation and interview on September 24, 2012, at 11:45 a.m., in the resident's room, revealed the resident lying on the bed, confirmed no desire to attend activities and preferred to relocate closer to family.

Interview with the MDS Coordinator on September 25, 2012, at 4:01 p.m., in the nurses' station, confirmed the Comprehensive Care Plan dated September 4, 2012, did not address measurable goals or interventions to address activities or community discharge.

F 280
SS=D
483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be

F 279

3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?

Monitoring of residents in activities both in room and in group activities, as well as daily activity sheets reflecting the residents level of activity.

Charts will be reviewed quarterly by activity director on an ongoing basis, with monthly meetings with activity aides to ensure individual activity plan of care is being met with all residents.

Continued -

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NAME OF PROVIDER OR SUPPLIER BLEDSOE COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367
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F 279 Continued From page 14

Resident #52 was admitted to the facility on May 23, 2012, with diagnoses including Cerebral Vascular Accident and Hypertension.

Medical record review of the activity assessment dated May 23, 2012, revealed the resident had been a "loner" before admission to the facility and preferred not to attend activities.

Medical record review of the Social Service notes dated September 4, 2012, revealed the resident desired to return to a private residence and preferred to relocate closer to family.

Medical record review of the Comprehensive Care Plan dated September 4, 2012, revealed no documentation of measurable goals or interventions for activities or community discharge.

Observation and interview on September 24, 2012, at 11:45 a.m., in the resident's room, revealed the resident lying on the bed, confirmed no desire to attend activities and preferred to relocate closer to family.

Interview with the MDS Coordinator on September 25, 2012, at 4:01 p.m., in the nurses' station, confirmed the Comprehensive Care Plan dated September 4, 2012, did not address measurable goals or interventions to address activities or community discharge.

F 280
SS=D **483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP**

The resident has the right, unless adjudged incompetent or otherwise found to be

F 279

4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?

Activity aide will report monthly to Director of Activity with activity sheets and note any type of deviation of level of activity for individual residents.

Activity Director will report to QA on a quarterly basis for next 6 months, beginning in November of 2012.

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NAME OF PROVIDER OR SUPPLIER BLEDSOE COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37387
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F 280 Continued From page 15
incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, interview, and review of facility documentation, the facility failed to evaluate and revise the care plan for two residents (13, #52) after a fall of twenty-four residents reviewed.

The findings included:
Resident #13 was admitted to the facility on May 19, 2009, with diagnoses including Diabetes Mellitus, Hypertension, Congestive heart Failure, and Mental Retardation.
Medical record review of the annual Minimum Data Set (MDS) dated May 30, 2012, revealed the resident had severe cognitive impairment,

F 280

F 280

1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?

Resident #13: The care plan was updated, 10/11/12 by the MDS Coordinator to reflect the interventions after the fall that occurred on 8/3/12

Resident #52: The care plan was updated by the MDS Coordinator on 10/11/12 to reflect the fall and interventions on 8/24/12

2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?

All charts and care plans were reviewed by the DON and MDS coordinator to check for revisions after falls. No other residents were affected.

11/10/12

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NAME OF PROVIDER OR SUPPLIER BLEDSOE COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367
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F 280	<p>Continued From page 16</p> <p>required supervision for transfers, required limited assistance for Activities of Daily Living (ADL's), and no restraint use.</p> <p>Medical record review of a Fall Risk Assessment dated May 12, 2012, revealed the resident was a high risk for falls.</p> <p>Review of a facility investigation dated August 3, 2012, revealed "...slid out of W/C (wheelchair) trying to get in bed..."</p> <p>Medical record review of the care plan last reviewed August 29, 2012, revealed no revision or update after the fall on August 3, 2012.</p> <p>Observation on September 24, 2012, at 10:13 a.m., in the dining room, revealed the resident sitting in a wheelchair with an econo-belt (safety belt restraint) in use.</p> <p>Interview with the MDS Coordinator on September 25, 2012, at 4:01 p.m., in the nurse's station, confirmed the care plan had not been revised/updated to reflect the fall, or interventions after the fall, on August 3, 2012.</p> <p>Resident #52 was admitted to the facility on May 23, 2012, with diagnoses including Cerebral Vascular Accident and Hypertension.</p> <p>Medical record review of the MDS dated September 14, 2012, revealed the resident was cognitively intact and required extensive assistance for Activities of Daily Living (ADL's) and transfers.</p> <p>Medical record review of the Fall Risk</p>	F 280	<p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>1:1 Discussion with the MDS Coordinator by the DON on 10/11/12 regarding care planning after a fall and including intervention put into place. Care plans will be reviewed by the DON and/or MDS coordinator after a resident fall to ensure interventions are documented.</p> <p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>The Care Plan team (MDS coordinator, social services, activity staff, dietary and DON) will review all falls and review the revised care plan for accuracy. Will report results in QA quarterly.</p>	

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2012
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NAME OF PROVIDER OR SUPPLIER BLEDSOE COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367
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(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
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F 280 Continued From page 17
Assessment dated June 12, 2012, revealed the resident was a high risk for falls.

Review of a facility investigation dated August 24, 2012, revealed the resident slid out of a wheelchair.

Medical record review of the care plan last reviewed September 4, 2012, revealed no revision or update after the fall on August 24, 2012.

Observation and interview on September 24, 2012, at 11:45 a.m., in the resident's room, revealed the resident lying on the bed.

Interview with the MDS Coordinator on September 25, 2012, at 4:01 p.m., in the nurse's station, confirmed the care plan had not been revised/updated to reflect the fall, or interventions after the fall, on August 24, 2012.

F 280

F 282

11/10/12

F 282
SS=D

483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, review of facility documentation, interview, and observation, the facility failed to follow physician's orders for one resident (#54) of twenty-four residents reviewed.

The findings included:

F 282

F 282

1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?

Resident #54: The charge nurses were instructed to follow physician orders and "HOLD" medications that have parameters such as for blood pressure and heart rate.

11/10/12

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NAME OF PROVIDER OR SUPPLIER BLEDSOE COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367
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(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 282	<p>Continued From page 18</p> <p>Resident #54 was admitted to the facility on August 17, 2012, with diagnoses including CVA (Stroke) with Right Sided Weakness, Dysphagia, Expressive Aphasia, and Hypertension.</p> <p>Medical record review of the physician's orders and Medication Administration Record (MAR) for August and September 2012, revealed an order dated August 17, 2012, for Carvedilol (blood pressure medication) 12.5 milligrams twice a day and hold the medication for systolic blood pressure less than 100 or heart rate less than 60.</p> <p>Medical record review of the MAR for September 1-25, 2012, revealed no doses of Carvedilol had been held. Further review of the MAR revealed no documentation of a blood pressure for twenty-one of fifty opportunities and no documentation of a heart rate for forty-two of fifty opportunities.</p> <p>Review of facility documentation revealed Certified Nursing Assistants (CNA) sometimes documented blood pressures and heart rates on daily assignment sheets and sometimes on pieces of paper. Further review of the documentation revealed blood pressures and heart rates were not consistently recorded twice a day, with blood pressures documented and no heart rate, or no documentation of either a blood pressure or heart rate. Further review of the documentation revealed the resident's heart rate was documented at 58 on September 6, 2012, for the 7:00 p.m. to 7:00 a.m. shift and 56 on September 24, 2012, for the 7:00 p.m. to 7:00 a.m. shift.</p>	F 282	<p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>Any resident who is on a blood pressure medication or medication to regulate the heart has the potential to be affected. All MARs were reviewed by the DON for potential residents. No other residents were found to be affected.</p> <p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>Inservice (for nurses) will be conducted by the DON 10/18/12. Discussed will include BP and HR to be documented on the MAR as well as holding medication when there are parameters given by the physician.</p> <p>Staff (nurses) who cannot attend inservice will have 1:1 instructions by the DON</p>	

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NAME OF PROVIDER OR SUPPLIER BLEDSOE COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367
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F 282	Continued From page 19 Interview with Licensed Practical Nurse (LPN) #1 on September 26, 2012, at 10:10 a.m., at the nursing station, confirmed there was no consistent system for documentation of blood pressures and heart rates by the CNAs. Further interview confirmed nursing was to document heart rate and blood pressure on the MAR. Further interview confirmed the heart rates and blood pressures had not been documented on the MAR, some heart rates and blood pressures were missing, and the Carvedilol had not been held when the heart rate was less than 60 as ordered by the physician.	F 282	4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? The DON will monitor MARs at least monthly to ensure compliance with parameters. Will report results in QA quarterly.	
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to confirm the placement for a Percutaneous Endoscopic Gastrostomy (PEG) for one resident (#48) of three residents with PEG tubes during a medication pass. The findings included: Resident #48 was admitted to the facility on May	F 322	1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE? Resident #48: The nurse checked placement using stethoscope and listening for air at the next medication administration. The Charge Nurses were reminded by the DON on correct procedure for checking placement of G Tubes.	11/10/12

BLEDSOE COUNTY NURSING HOME

107 Wheelertown Ave.
P.O. Box 250
Pikeville, TN 37367
(423) 447-6811

Date 11/7/12

FAX NUMBER: (423) 447-5289

TO: Donna Smith

FROM: Stephanie Baylton

RE: POC - 9/26/12 - correction/change

Total 48 PAGES (Including Transmittal Sheet)

- PLEASE:
- Read
 - Handle
 - Approve
 - Call Me
 - Other

Batch 1 -
(Pages 1-24)

Batch 2 -
Pages 25-48

ADDITIONAL COMMENTS:

Please let me know if you
Have any questions!

CONFIDENTIAL NOTE

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER BLEDSOE COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367
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F 322 Continued From page 20
18, 2012, with diagnoses including Dementia, Hypertension and Coronary Artery Disease.

Observation during a medication pass on September 24, 2012, at 10:45 a.m., with Licensed Practical Nurse (LPN) #2, revealed the nurse flushed the PEG tube with water, checked for residual content prior to giving the medication through the PEG tube, but failed to check the position of the PEG tube prior to administering the medications.

Review of facility policy, Enteral Nutritional Therapy (Tube Feeding), with no date, revealed "...remove plug end of feeding tube, check position of tube, and attach barrel of syringe to end of the tubing...check position of tube by: (c) Place stethoscope over stomach and instill a small amount of air into the enteral feeding tube...listen for air to enter the stomach..."

Interview with LPN #2 on September 24, 2012, at 11:15 a.m., in the A Wing Hallway, confirmed the LPN failed to check the placement of the PEG tube prior to giving medications and failed to follow facility policy.

F 323
SS=D 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

F 322

2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?

Residents who have G tubes have the potential to be affected. The DON observed the nurses for the next week during at least one (1) medication administration and found no other resident affected.

Observations by the DON weekly for call light and alarm placement found no other resident affected.

3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?

1:1 discussion with the nurse involved occurred 9/24/12 by the DON

Inservice will be conducted 10/18/12 with Nursing Staff, by the DON. G Tube policy will be reviewed at that time.

Nurses who cannot attend inservice will have 1:1 instructions by the DON

Continued

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F 322	<p>Continued From page 20</p> <p>18, 2012, with diagnoses including Dementia, Hypertension and Coronary Artery Disease.</p> <p>Observation during a medication pass on September 24, 2012, at 10:45 a.m., with Licensed Practical Nurse (LPN) #2, revealed the nurse flushed the PEG tube with water, checked for residual content prior to giving the medication through the PEG tube, but failed to check the position of the PEG tube prior to administering the medications.</p> <p>Review of facility policy, Enteral Nutritional Therapy (Tube Feeding), with no date, revealed "...remove plug end of feeding tube, check position of tube, and attach barrel of syringe to end of the tubing...check position of tube by: (c) Place stethoscope over stomach and instill a small amount of air into the enteral feeding tube...listen for air to enter the stomach..."</p> <p>Interview with LPN #2 on September 24, 2012, at 11:15 a.m., in the A Wing Hallway, confirmed the LPN failed to check the placement of the PEG tube prior to giving medications and failed to follow facility policy.</p>	F 322	<p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>The Charge nurses will be monitored by the DON(monthly, randomly) to ensure compliance with appropriate procedure for checking placement. Results will be reported to QA quarterly. Will monitor for 6 months.</p>	
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p>	F 323		

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F 323	<p>Continued From page 21</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review, review of manufacturer's recommendations, observation, interview, and review of Material Safety Data Sheets (MSDS), the facility failed to ensure a restraint device had been applied correctly for one resident (#13) of twelve residents reviewed for restraints and failed to ensure personal safety alarms were in place for three residents (#13, #3, #24) of seven residents reviewed for accidents of twenty-four residents reviewed.</p> <p>The findings included:</p> <p>Resident #13 was admitted to the facility on May 19, 2009, with diagnoses including Diabetes Mellitus, Hypertension, Congestive Heart Failure, and Mental Retardation.</p> <p>Medical record review of the annual Minimum Data Set (MDS) dated May 30, 2012, revealed the resident had severe cognitive impairment, required supervision for transfers, required limited assistance for Activities of Daily Living (ADL's), and no restraint use.</p> <p>Medical record review of the quarterly MDS dated August 29, 2012, revealed the resident used a trunk restraint daily.</p> <p>Medical record review of the care plan last reviewed August 29, 2012, revealed "...non self release seat belt to w/c (wheelchair) when up for safety...bed/chair alarm..."</p> <p>Medical record review of the Physician's September recapitulation orders dated</p>	F 323	<p><u>F 323</u></p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>Resident #13: A smaller wheelchair was order to accommodate the proper placement of the restraint. Also chair alarm was placed on resident while in wheelchair as ordered.</p> <p>The box of ice cream salt was removed from cart by the Administrator</p> <p>Resident #3: The call light was placed within reach of the resident by the staff.</p> <p>Resident #24: The call light was placed within reach of the resident and the bed alarm was attached properly to the resident by the staff.</p>	11/10/12
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NAME OF PROVIDER OR SUPPLIER BLEDSOE COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367
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F 323 Continued From page 22
September 1, 2012, through September 30, 2012, revealed "...seatbelt when up in w/c..."

Review of the manufacturer's recommendations for application of the econo-belt revealed "...cross the straps and place the right loop over the left kick spur and the left loop over the right kick spur..."

Observation on September 24, 2012, at 10:13 a.m., in the dining room, revealed the resident sitting in a wheelchair with an econo-belt (safety belt restraint) in use and no personal safety alarm. Further observation at this time revealed the straps through the space between the wheelchair seat and the back rest and the left loop over the left kick spur and the right loop over the right kick spur.

Interview with the Director of Nursing (DON) on September 25, 2012, at 7:45 a.m., in the DON's office, confirmed the facility failed to apply a personal safety alarm, and failed to apply the econo-belt according to manufacturer's recommendations.

Observation on September 23, 2012, at 4:45 p.m., revealed an activity cart used by the Activity Department in the hallway outside the dining room. Continued observation revealed a four pound box of ice cream salt full. Continued observation revealed there were no residents in the hallway.

Review of the Material Safety Data Sheet (MSDS) for the ice cream salt revealed "...Hazards Identification-intake of large amounts...following effects were observed...vomiting.

F 323

2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?

The charts were reviewed by the DON for residents who have restraints, each resident was then observed by the DON for proper placement of restraint. This was done by 10/12/12
During weekly observation rounds by the DON, call lights and bed/personal alarms were monitored for proper placement. No other resident was affected.

3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?

Inservice will be conducted by the DON on 10/18/12. Will review the manufactures recommendations for proper application.
Also to be discussed is call light placement as well as bed/chair alarm proper placement.

Continued

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F 323	<p>Continued From page 23 diarrhea...dehydration...high blood pressure...shock...pulmonary edema...first aid measures...eye contact, flush with water immediately..."</p> <p>Observation and interview on September 23, 2012, at 4:50 p.m., with the Administrator, in the hallway, confirmed the ice cream salt was labeled not for human consumption and was unattended in a resident area.</p> <p>Resident #3 was admitted to the facility on June 28, 2011, with diagnoses including Dementia, Hypertension, Osteoarthritis, and Alzheimers Disease.</p> <p>Medical record review of the Annual Minimum Data Set (MDS) dated July 11, 2012, revealed the resident had severely impaired cognition; required limited to extensive assistance with all Activities of Daily Living (ADLs); and had not experienced any falls since the last assessment.</p> <p>Medical record review of the nursing notes dated July 9, 2011, revealed the resident had an unattended fall out of bed, with no injuries, and no other falls were documented in the medical record.</p> <p>Medical record review of the care plan updated September 19, 2011, revealed, "...fall from standing position. Potential for further falls...keep call light in reach at all times when in room...bed alarm when in bed..."</p> <p>Medical record review of the physician's recapitulation orders for September 2012, revealed, "...bed alarm when in bed..."</p>	F 323	<p>Inservice included nurses, C.N.A.s, housekeeping, maintenance, social services and activity staff</p> <p>Those staff members who cannot attend the inservice at that time will be given 1:1 instructions by the DON or substitute.</p> <p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>The DON or appointed substitute will monitor residents with seat belt restraints for proper placement. DON, or approp. substitute will make observation rounds at least weekly and observe for call light and bed/personal alarm for proper placement. Will report to QA quarterly for 6 months.</p>	

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F 323	<p>Continued From page 24</p> <p>Observation on September 23, 2012, at 3:00 p.m., in the resident's room, revealed the resident was lying in bed and the call light was dangling below the bed, in between the mattress and the side rails, out of reach for the resident, and the bed alarm was present, but not attached to the resident.</p> <p>Interview with Certified Nursing Assistant (CNA) #7 on September 23, 2012, at 3:00 p.m., in the resident's room, confirmed the call light was out of reach; the resident was capable of using the call light to call for assistance; and the bed alarm was to be attached to the resident, but was not.</p> <p>Resident #24 was admitted to the facility on May 14, 2010, with diagnoses including Hypertension, Osteoarthritis, Anemia, Edema, and Depression.</p> <p>Medical record review of the Quarterly MDS dated July 25, 2012, revealed the resident had severely impaired cognition; was totally dependent on staff for all ADLs; and had not experienced any falls since the last assessment.</p> <p>Medical record review revealed the resident's last fall was on August 27, 2010, while transferring to the wheelchair, with no injuries.</p> <p>Medical record review of the care plan updated on August 24, 2011, revealed, "...at risk for fall/injury...keep call light in reach at all times when in room...2/8/12 bed/chair alarm @ (at) all times..."</p> <p>Observation on September 23, 2012, at 3:00 p.m., in the resident's room, revealed the resident</p>	F 323	<p><u>F 323</u> Ice Cream Salt _____</p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>Staff will be in serviced to tell all visitors not to leave unused supplies in resident areas.</p> <p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>Activity staff will be inserviced as to insuring a safe storage area and removing any item that could possibly be hazardous to residents</p>	11/10/12
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NAME OF PROVIDER OR SUPPLIER BLEDSOE COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37387
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(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)	(X6) COMPLETION DATE
F 323	Continued From page 25 was lying in bed, with the call light wedged between the padding on the side rail and the side rail, not visible to the resident, and out of reach for the resident, and the bed alarm was present, but not attached to the resident.	F 323	<p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>Activity staff will check their equipment and carts for such items.</p> <p>Ice cream chart will be monitored daily by activity staff or appropriate substitute, on an ongoing basis.</p> <p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>Activity staff will report any occurrence to Director of Activities for appropriate action.</p> <p>Activity Director will report to QA quarterly for 6 months beginning 11/12.</p>	
F 329 SS=D	<p>Interview with CNA #7 on September 23, 2012, at 3:00 p.m., in the resident's room confirmed the call light was out of reach; the resident was capable of using the call light to call for assistance; and the bed alarm was to be attached to the resident and was not.</p> <p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</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>	F 329		

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2012
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NAME OF PROVIDER OR SUPPLIER BLEDSOE COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367
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F 329	<p>Continued From page 26</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to ensure unnecessary medications were not administered for one resident (#40) of ten sampled residents of twenty-four residents reviewed.</p> <p>The findings included:</p> <p>Resident #40 was admitted to the facility on May 18, 2010, with diagnoses including Anxiety, Hypertension, and Arthritis.</p> <p>Medical record review of a physician's telephone order dated July 24, 2012, revealed "...obtain UA (urinalysis) with C/S (culture and sensitivity) if indicated..."</p> <p>Medical record review of a laboratory report dated July 24, 2012, revealed a Urinalysis had been collected on July 24, 2012.</p> <p>Medical record review of a physician's telephone order dated July 25, 2012, revealed "...Cipro (antibiotic) 500 mg (milligram) po (per mouth) BID (twice daily) x (times) 7 days DX (diagnosis) UTI (urinary tract infection)..."</p> <p>Medical record review of the final culture report dated July 26, 2012, revealed the organism Escherichia coli had been identified and was not sensitive to Ampicillin.</p> <p>Medical record review of a physician's telephone</p>	F 329	<p>F 329</p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>Resident #40: Physician had a copy of the sensitivity report when ordering antibiotic. The resident finished antibiotic with and problems noted.</p> <p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>Any resident who has a culture ordered has the potential to be affected. The current residents on antibiotics were reviewed by the DON for proper treatment 10/12/12</p>	11/10/12
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/05/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2012
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F 329 Continued From page 27
order dated July 26, 2012, revealed "...D/C (discontinue) Cipro 500 mg BID Ampicillin (antibiotic) 500 mg po BID x 7 days DX: UTI..."

Interview with the Director of Nursing (DON) on September 25, at 10:11 a.m., in the nurses' station, confirmed the organism was not sensitive to Ampicillin, the facility failed to notify the physician, and the resident received seven days of an unnecessary medication.

F 354 SS=F 483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON

Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.

The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

This REQUIREMENT is not met as evidenced by:
Based on review of staffing and interview, the facility failed to have a registered nurse for at least eight consecutive hours a day, seven days a week.

The findings included:
Review of the September 2012 staffing schedule

F 329

3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?

An inservice (with nurses) will be conducted by the DON on 10/18/12 will include paying particular attention to the sensitivity report when calling the physician results. Will instruct staff to notify physician if antibiotic is resistant to the organism.

For those nurses who are unable to attend the inservice, they will have 1:1 instruction by the DON or appropriate substitute.

4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?

DON or appropriate substitute will monitor each sensitivity report for appropriate antibiotic usage, for 6 months.
Results will be reported in QA quarterly.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER BLEDSOE COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367		
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F 329	Continued From page 27 order dated July 26, 2012, revealed "...D/C (discontinue) Cipro 500 mg BID Ampicillin (antibiotic) 500 mg po BID x 7 days DX: UTI..."	F 329			
F 354 SS=F	Interview with the Director of Nursing (DON) on September 25, at 10:11 a.m., in the nurses' station, confirmed the organism was not sensitive to Ampicillin, the facility failed to notify the physician, and the resident received seven days of an unnecessary medication. 483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of staffing and interview, the facility failed to have a registered nurse for at least eight consecutive hours a day, seven days a week. The findings included: Review of the September 2012 staffing schedule	F 354	F 354 1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE? On 9/26/12 a letter was submitted to Director of Certification and the Director of Health Care Facilities and Bureau of TennCare. This letter is requesting a waiver of the RN Requirement due to the nursing home being attached to a hospital. On 11/6/12 we were asked to submit further documentation for the waiver request. This will be submitted 11/7/12. Until notification of the waiver is received our current RN staff will work overtime hours to cover the weekend shifts.	11/10/12	

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F 354	<p>Continued From page 28</p> <p>for Licensed and Registered Nurses revealed there were no Registered Nurses (R.N.) scheduled for Saturdays or Sundays.</p> <p>Review of a letter dated March 24, 1992, revealed R.N. coverage was not required due to having a small hospital attached to the facility and R.N. coverage could be provided to the facility from the hospital staff.</p> <p>Interview with the Administrator on September 25, 2012, at 10:00 a.m., in the Administrator's office, confirmed the letter was 20 years old and was not an RN waiver. The Administrator also confirmed the facility failed to have Registered Nurses scheduled eight consecutive hours a day, seven days a week.</p>	F 354	<p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>All residents have the potential to be affected by this practice. It has been determined by the Director of Nursing for the facility that no current patient requires clinical care from an RN. We will not admit any resident who requires clinical care from an RN.</p>	
F 371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility's dietary department failed to maintain sanitary conditions for equipment and storage areas, and failed to properly store food in the nourishment room.</p>	F 371	<p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>On 9/26/12 a letter was submitted to Director of Certification and the Director of Health Care Facilities and Bureau of TennCare. This letter is requesting a waiver of the RN</p>	

Continued

CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 354	Continued From page 28 for Licensed and Registered Nurses revealed there were no Registered Nurses (R.N.) scheduled for Saturdays or Sundays. Review of a letter dated March 24, 1992, revealed R.N. coverage was not required due to having a small hospital attached to the facility and R.N. coverage could be provided to the facility from the hospital staff. Interview with the Administrator on September 25, 2012, at 10:00 a.m., in the Administrator's office, confirmed the letter was 20 years old and was not an RN waiver. The Administrator also confirmed the facility failed to have Registered Nurses scheduled eight consecutive hours a day, seven days a week.	F 354	Requirement due to the nursing home being attached to a hospital. On 11/6/12 we were asked to submit further documentation for the waiver request. This will be submitted 11/7/12. Until notification of the waiver is received our current RN staff will work overtime hours to cover the weekend shifts.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility's dietary department failed to maintain sanitary conditions for equipment and storage areas, and failed to properly store food in the nourishment room.	F 371		

Continued

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2012
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F 354	<p>Continued From page 28 for Licensed and Registered Nurses revealed there were no Registered Nurses (R.N.) scheduled for Saturdays or Sundays.</p> <p>Review of a letter dated March 24, 1992, revealed R.N. coverage was not required due to having a small hospital attached to the facility and R.N. coverage could be provided to the facility from the hospital staff.</p> <p>Interview with the Administrator on September 25, 2012, at 10:00 a.m., in the Administrator's office, confirmed the letter was 20 years old and was not an RN waiver. The Administrator also confirmed the facility failed to have Registered Nurses scheduled eight consecutive hours a day, seven days a week.</p>	F 354	<p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>The schedule will be changed to include the DON or MDS coordinator to cover the weekend shifts until we receive a response from the waiver request. This will be monitored by the DON and administrator.</p>	
F 371: SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility's dietary department failed to maintain sanitary conditions for equipment and storage areas, and failed to properly store food in the nourishment room.</p>	F 371		

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F 371 Continued From page 29

The findings included:

Observation of the dietary department on September 23, 2012, beginning at 10:13 a.m., with the facility's cook present, revealed the following:

1. The exterior perimeter of the walk-in refrigerator's condenser unit, including pipe, and ceiling above the condenser unit, had accumulation of blackened debris.
2. Two beverages, with a staff member's name written on each cup, were stored in the walk-in refrigerator.
3. A plastic covered large mixer with grease on the descending nut from the underside of the beater arm and white powder residue on the exterior upper rim of the splash guard and backside of the mixer bowl arm. Interview with the cook, at the time of the observation, confirmed the plastic covered equipment meant the equipment was clean and ready for use.

Interview with the cook, present during the observation on September 23, 2012, beginning at 10:13 a.m., in the dietary department, confirmed the facility failed to maintain sanitary conditions for equipment and storage areas. Further interview with the cook, confirmed employee beverages were not to be stored in resident food areas.

Observation of the refrigerator in the Nourishment Room on September 26, 2012, at 10:25 a.m., revealed a resident's covered food plate containing onion rings, mashed potatoes, and a

F 371

F_371

1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?

1. The refrigerator coils, pipe and ceiling above the condenser unit was cleaned on September 23, 2012.
2. No staff will keep any beverages in the walk-in refrigerator.
3. Large stand mixer will be cleaned after each use and checked.
4. No food or drink will be kept in the resident refrigerator without a label stating, kind of food, name, date, and use by date.

2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?

1. All residents at the facility can be affected.
2. All residents can be affected.
3. All residents can be affected.
4. All residents can be affected.

11/10/12

Continued

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F 371	<p>Continued From page 29</p> <p>The findings included:</p> <p>Observation of the dietary department on September 23, 2012, beginning at 10:13 a.m., with the facility's cook present, revealed the following:</p> <ol style="list-style-type: none"> 1. The exterior perimeter of the walk-in refrigerator's condenser unit, including pipe, and ceiling above the condenser unit, had accumulation of blackened debris. 2. Two beverages, with a staff member's name written on each cup, were stored in the walk-in refrigerator. 3. A plastic covered large mixer with grease on the descending nut from the underside of the beater arm and white powder residue on the exterior upper rim of the splash guard and backside of the mixer bowl arm. Interview with the cook, at the time of the observation, confirmed the plastic covered equipment meant the equipment was clean and ready for use. <p>Interview with the cook, present during the observation on September 23, 2012, beginning at 10:13 a.m., in the dietary department, confirmed the facility failed to maintain sanitary conditions for equipment and storage areas. Further interview with the cook, confirmed employee beverages were not to be stored in resident food areas.</p> <p>Observation of the refrigerator in the Nourishment Room on September 26, 2012, at 10:25 a.m., revealed a resident's covered food plate containing onion rings, mashed potatoes, and a</p>	F 371	<p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <ol style="list-style-type: none"> 1. The refrigerator coils, pipe and ceiling will be cleaned on a monthly basis or if needed to be cleaned sooner, as part of our regular cleaning of this refrigerator. Staff will receive an inservice on not keeping any personal beverages in the walk-in cooler. 2. All dietary staff will receive an inservice on not keeping any personal drinks or food in the walk-in refrigerator. 3. All dietary staff will receive and inservice on the large stand mixer 4. Dietary staff and CNA's will receive an inservice on labeling and dating any food or drink put in the resident refrigerator. Labels are provided on a clip board for staff to use to label and food stored in the resident refrigerator. Visitors will not have access to the resident refrigerator. 	
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F 371	<p>Continued From page 30</p> <p>mechanically altered meat, setting on top of individual servings of juices.</p> <p>Interview with the Administrator on September 26, 2012, at 10:25 a.m., in the Nourishment Room, confirmed the plate "looks like a resident tray," was not labeled with a date or name, and was not to be stored in refrigerator.</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide pharmacy services in a timely manner for one</p>	F 371	<p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>1. The walk-in refrigerator will be inspected weekly by the dietary supervisor .</p> <p>2. The walk-in refrigerator will be monitored an a daily basis.</p> <p>3. The large stand mixer will be checked each day by the dietary supervisor.</p> <p>3. The walk-in refrigerator will be monitored daily by dietary supervisor.</p>	F 425 SS=D

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F 425 Continued From page 31 resident (#55) of ten residents reviewed during a medication administration observation.

The findings included:

Resident #55 was admitted to the facility on September 11, 2012, with diagnoses including Edema, Depression, Atrial Fibrillation, and Arthritis.

Medical record review of a Physician's Admission orders dated September 11, 2012, through September 30, 2012, revealed "...Rocalitrol (vitamin) 0.25 mg (milligram) 1 po (per mouth) daily..."

Medical record review of a Medication Administration Record dated September 11, 2012, through September 30, 2012, revealed Rocalitrol 0.25 mg was not administered September 12, 22, and 23, 2012.

Interview with Licensed Practical Nurse (LPN) #1 on September 23, 2012, at 11:23 a.m., in the nurse's station, confirmed the Rocalitrol 0.25 mg had not been available from the pharmacy on September 12, 22, and 23, 2012, and the medication had not been given.

Interview with the Pharmacist on September 25, 2012, at 2:00 p.m., by telephone, confirmed the Rocalitrol had not been available.

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

F 425

F 425

1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?

Resident #55: The pharmacy sent al the medication that was on hand to be given. The medication was not available from their normal distributor on Thursday, they then ordered from another distributor on Friday, however no weekend deliveries are made to the pharmacy. The medication arrived on Monday as the pharmacy sent the medication to the facility for the next scheduled dose.

2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?

All charts (MARs) were reviewed by the DON and no other residents were found to be affected.

11/10/12

Continued

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2012
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NAME OF PROVIDER OR SUPPLIER BLEDSOE COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367
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(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 425	Continued From page 31 resident (#55) of ten residents reviewed during a medication administration observation. The findings included: Resident #55 was admitted to the facility on September 11, 2012, with diagnoses including Edema, Depression, Atrial Fibrillation, and Arthritis. Medical record review of a Physician's Admission orders dated September 11, 2012, through September 30, 2012, revealed "...Rocalitrol (vitamin) 0.25 mg (milligram) 1 po (per mouth) daily..." Medical record review of a Medication Administration Record dated September 11, 2012, through September 30, 2012, revealed Rocalitrol 0.25 mg was not administered September 12, 22, and 23, 2012. Interview with Licensed Practical Nurse (LPN) #1 on September 23, 2012, at 11:23 a.m., in the nurse's station, confirmed the Rocalltrol 0.25 mg had not been available from the pharmacy on September 12, 22, and 23, 2012, and the medication had not been given. Interview with the Pharmacist on September 25, 2012, at 2:00 p.m., by telephone, confirmed the Rocalitrol had not been available.	F 425	3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? In the future, as soon as it becomes apparent to the pharmacist that a medication will not be available at the next scheduled dose time, they will contact the nursing staff who will then contact the physician for alternative orders. This will be discussed by the DON at the inservice 10/18/12 to nurses. For those nurses not able to attend the inservice a 1:1 discusion will be held with them by the DON or approp. substitute.	
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	F 431	4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? This will be monitored (for at least 6 months) by the DON and the Pharmacist for proper compliance and notification. The results will be reported to QA quarterly.	

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F 431	<p>Continued From page 32</p> <p>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.</p> <p>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.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to ensure drugs and biologicals were secured for one of one treatment carts in the facility.</p>	F 431	<p>F 431</p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>Treatment cart was locked upon notification. Treatment cart will be kept locked when unattended.</p> <p>Also the bottles of sanitizer were removed from top of the cart and secured.</p> <p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>The treatment cart had been observed by the DON each morning upon arrival (Monday thru Friday) and on random observations throughout the day, with no other occurrences.</p> <p style="text-align: right;"><i>Continued</i></p>	11/10/12
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F 431	<p>Continued From page 32</p> <p>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.</p> <p>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.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to ensure drugs and biologicals were secured for one of one treatment carts in the facility.</p>	F 431	<p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>Inservice (to nurses) will be conducted 10/18/12 by the DON, included will be the importance of keeping treatment (as well as med cart) locked when left unattended. Also included will be the necessity of keeping sanitizers out of reach of the residents. Any nurse who is unable to attend inservice will have 1:1 instruction of content of inservice.</p>	
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F 431	Continued From page 33 The findings included: Observation on September 25, 2012, at 4:30 p.m., in the hallway outside of the nurses station, revealed an unlocked and unattended treatment cart with two bottles of cleaner for the glucometer on the top of the cart. Review of facility policy, Pharmacy Services, with no date, revealed "...all drugs and biological are stored in locked compartments under proper temperature controls..." Interview with Licensed Practical Nurse (LPN) #7, on September 25, 2012 at 4:30 p.m., confirmed the treatment cart was unlocked and unattended and contained drugs and biologicals which were not secured.	F 431	4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? DON or appropriate substitute will monitor the treatment cart, for at least 6 months, to ensure it is locked when unattended and to ensure compliance with sanitizers being kept out of reach of residents when cart is left unattended. Results will be reported in QA quarterly.	
F 441 SS=E	483.85 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	F 441	F 441 1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE? Resident # 29, #43, #2 and #21: At the next accu-check, the nurse sanitized her hands between finger sticks and administration of insulin. The door locks on the storage closet were changed and doors locked by maintenance on 9/23/12. Instruction provided to staff (verbally) by DON 9/23/12	11/10/12

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F 441	<p>Continued From page 34</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to follow infection control practices for four residents (#29, #43, #2, #21) of twenty-four residents reviewed, and failed to ensure supplies and equipment were stored in a clean manner for one storage closet.</p> <p>The findings included:</p> <p>Observation on September 25, 2012, at 11:15 a.m., in the dining room, revealed resident #29 eating lunch. Further observation at this time revealed a LPN removed the resident from the dining room and took the resident to the hallway and LPN #3 performed an accucheck and administered insulin without washing the hands.</p>	F 441	<p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>Observations by the DON at weekly during finger sticks for privacy and for approp. hand sanitizing, has found no other residents to be affected.</p> <p>Also observations by the DON on random occasions weekly, have found no other residents affected by staff not sanitizing hands between resident care.</p> <p>Also any resident who is independent with mobilization had the potential to be affected. However no other resident has been affected since the doors are locked and only authorized personel (nursing, materials management and maintenance) have control of the key.</p>	

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F 441	<p>Continued From page 35</p> <p>Observation on September 25, 2012, at 11:18 a.m., in the dining room, revealed resident #43 eating lunch. Further observation at this time revealed a LPN removed the resident from the dining room and took the resident to the hallway and LPN #3 performed an accucheck without washing the hands.</p> <p>Observation on September 25, 2012, at 11:20 a.m., in the dining room, revealed resident #2 eating lunch. Further observation at this time revealed a LPN removed the resident from the dining room and took the resident to the hallway and LPN #3 performed an accucheck and administered insulin without washing the hands.</p> <p>Review of the facility's policy Hand Washing revised May 25, 2001, revealed "...Hands should be thoroughly washed before and after providing resident care..."</p> <p>Interview on September 25, 2012, at 11:25 a.m., in the hallway, with LPN #3, confirmed the LPN failed to wash the hands between performing an accucheck for one resident (#2) and performing accuchecks and administering insulin injections for two residents (#29, #43).</p> <p>Observation on September 25, 2012, at 1:35 p.m., in the hallway, revealed Certified Nurse Aide (CNA) #6 exit resident #42's room, with ungloved hands and placed soiled linen in the soiled linen cart. Further observation at this time revealed the CNA entered resident #21's room, without washing the hands, and placed ice and water in the water pitcher.</p>	F 441	<p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>Nurses were verbally reminded by the DON on 9/23/12 regarding proper hand hygiene between resident contact. Also staff (nursing, maintenance and material management) were verbally instructed regarding locking of the doors to the storage closet.</p> <p>Inservice will be conducted 10/18/12 by the DON reviewing hand hygiene policy and instruction regarding keeping the doors to the storage closet locked. (Inservice included nurse, c.n.a.'s, housekeeping, maintenance, social services and activity depts.)</p>	
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F 441	<p>Continued From page 36</p> <p>Review of the facility's Infection Control Policy no date revealed "...all employees are required to wash their hands after each direct resident contact..."</p> <p>Interview on September 25, 2012, at 1:38 p.m., in the hallway, with CNA #6 confirmed hand washing had not been performed after direct contact with residents.</p> <p>Interview with the Director of Nursing (DON) on September 25, 2012, at 2:30 p.m., in the DON office, confirmed the facility failed to follow infection control practices.</p> <p>Observation on September 23, 2012, at 3:45 p.m., in resident rooms 101 and 103, revealed a storage closet unlocked. Continued observation at this time revealed equipment and medical supplies stored in the closet and the entrance was made through the resident rooms.</p> <p>Observation and interview with the Administrator on September 23, 2012, at 3:51 p.m., in room 103, confirmed the room was unlocked, used for equipment and medical supplies, and entrance and exit from the storage room with clean supplies and equipment was made through the resident's rooms.</p>	F 441	<p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>DON will monitor the nurses during glucose check and insulin administration 1 time each and as needed to ensure compliance with hand hygiene. Results will be reported in QA quarterly. DON and Administrator will monitor closet doors for compliance for 6 months, results will be reported in QA quarterly.</p>	
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