

CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 4/12/14

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 02/26/2014
--------------------------------------------------	------------------------------------------------------------------	------------------------------------------------------------------	----------------------------------------------

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 000	INITIAL COMMENTS	F 000		
F 221 SS=E	<p>During complaint investigation #31140, and #31451, conducted during the annual recertification survey on February 24, through February 26, 2014, no deficiencies were cited in relation to complaint #31140.</p> <p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, observation, and interview, the facility failed to assess and/or obtain consent for physical restraints for three residents (#18, #17, and #40) of seven residents reviewed for physical restraints, of twenty-seven residents reviewed.</p> <p>The findings included:</p> <p>Resident #18 was readmitted to the facility on May 14, 2010, with diagnoses including Anxiety, Chronic Pain, Hypertension, Hyperlipidemia, and Osteoarthritis.</p> <p>Medical record review of the quarterly Minimum Data Set (MDS) dated January 22, 2014, revealed the resident scored a one on the Brief Interview for Mental Status, indicating the resident had severe cognitive impairment, was totally dependent of two persons for bed mobility and transfers, bed rails were used daily, and a trunk</p>	F 221	<p><u>F 221</u></p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>Resident #18: New Pre-restraining Assessment completed and Restrain consent obtained by phone from POA on 3/5/14</p> <p>Resident #17: New Pre-restraining assessment was completed and restraint consent obtained 2/26/14</p> <p>Resident #40: Met with APS representative (who is over resident) on 2/27/14, explained side rails and lap buddy. Gave consent to APS rep who will take to her supervisor for direction on exactly who can sign. If APS is unable to give consent, will inform physician and have him give consent. By 3/31/14</p>	3-3-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Stephanie Byrd</i>	TITLE <i>Administrative</i>	(X8) DATE 3/3/14
------------------------------------------------------------------------------------------------	--------------------------------	---------------------

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.

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 02/26/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

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 221	<p>Continued From page 1 restraint was used less than daily.</p> <p>Medical record review of the physician's recapitulation orders for February 2014, revealed a seat belt was to be used when the resident was seated in a wheelchair.</p> <p>Medical record review revealed no documentation a Pre-restraining or restraint assessment had been completed for the use of the seat belt restraint.</p> <p>Review of the facility's policy Restraints (Physical), undated, revealed "...General Resident Rights Guidelines...Include resident's family and surrogate health care decision-makers in care planning...Obtain informed consent for restraint use...Assess resident's need for restraint use..."</p> <p>Observation on February 25, 2014, at 10:10 a.m., revealed the resident seated in a wheelchair, in the common area near the nursing station, with a seat belt restraint in place.</p> <p>Interview on February 25, 2014, at 12:50 p.m., with the Director of Nursing, in the conference room, confirmed a restraint assessment had not been completed for the use of the seat belt, and there was no signed consent for the use of the seat belt restraint.</p> <p>Resident #17 was admitted to the facility on October 16, 2012, and readmitted to the facility on January 25, 2013, with diagnoses including Dementia, Anemia, Psychosis, and Delusions.</p> <p>Medical record review of a physician's order</p>	F 221	<p>2.)HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>Charts were reviewed on all residents who require restraints, including side rails, lap buddies and seat belts. New Pre-restraining assessments will be completed in all these residents by 3/31/14 by the charge nurses.</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 nursing staff (RNs, LPNs and CNAs) on 3/12/14 to discuss restraints, pre-restraining assessments, side rail assessments and restraint consents. New pre-restraining assessments, side rail assessments and consents will be obtained and copy placed in note book to be kept at the desk for frequent review by staff. By 3/31/14 New employees will be inserviced by reading the minutes of the staff meeting and signing/dating.</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 02/26/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

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 221	<p>Continued From page 2 dated January 26, 2013, revealed "...non-self release seat belt..."</p> <p>Medical record review of the physician's recapitulation orders dated February 1, through February 28, 2014, revealed "...Seat belt when in (wheelchair) release Q (every) 2 hr (hours), check q 30 min (minutes)..."</p> <p>Medical record review of the pre-restraining assessment (undated) revealed the assessment was incomplete.</p> <p>Observation on February 25, 2014, at 10:40 a.m., revealed the resident seated in a wheelchair, in the hall, with a non release seat belt restraint in place.</p> <p>Interview on February 25, 2014, at 1:00 p.m., in the conference room with the Director of Nursing (DON), confirmed the pre-restraint assessment was not complete.</p> <p>Interview on February 26, 2014, at 12:20 p.m., with the DON, in the conference room, confirmed no consent was obtained from the resident's family for the use of the seat belt restraint.</p> <p>Resident #40 was admitted to the facility on August 17, 2012, with diagnoses including CVA (Cerebrovascular Accident) (with) R (right) side weakness, and Seizure Disorder.</p> <p>Medical record review of the Quarterly Minimum Data Set (MDS) dated November 29, 2013, revealed the resident used bed rails daily as a restraint.</p> <p>Medical record review of the physician's</p>	F 221	<p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>All completed assessments, and consents will be routed to the DON who will copy, review and place in note book. This book will be reviewed for accuracy at least monthly by the DON, including when a restraint is placed or changed. QA committee will monitor monthly for at least 6 months.</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 02/26/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

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 221	<p>Continued From page 3</p> <p>recapitulation orders dated February 1, 2014, through February 28, 2014, revealed "Side Rail up for positioning/mobility..."</p> <p>Medical record review of the Side Rail Assessment dated August 17, 2012, revealed "...Does the resident use the side rails for positioning or support?...yes...Recommendations...Side Rails...Bilateral..."</p> <p>Medical record review revealed no documentation a side rail assessment or restraint assessment had been completed since August 17, 2012.</p> <p>Observation on February 24, 2014, at 10:19 a.m., revealed the resident lying on the bed with four quarter side rails in the raised position.</p> <p>Interview on February 25, 2014, at 1:00 p.m., with Licensed Practical Nurse #1, in the hall, confirmed the resident was able to get out of the bed.</p> <p>Interview on February 25, 2014, at 3:15 p.m., with the Director of Nursing, in the conference room, confirmed no-restraint assessment had been completed for the use of the side rails as a restraint.</p>	F 221		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p>	F 280	<p>F F-280</p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p>	3-31-14

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 02/26/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

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 280	<p>Continued From page 4</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to revise the Care Plan for three residents (#10, #35, and #23) of twenty-seven residents reviewed.</p> <p>The findings included:</p> <p>Resident #10 was admitted to the facility on January 31, 2014, with diagnoses including Bladder Cancer, Hypertension, Diabetes, Anxiety, Depression, History of Chronic Obstructive Pulmonary Disease, History of Congestive Heart Failure, and Cerebrovascular Accident.</p> <p>Medical record review of the physician's recapitulation orders for February 2014, revealed the resident received Prozac (antidepressant) 40 mg (milligrams) daily, and Alprazolam (antianxiety) 0.5 mg three times a day.</p> <p>Medical record review of the Admission Care Plan</p>	F 280	<p>Resident #10: Medication monitoring and side effects were included on the Comprehensive Care plan 2/27/14 MDS Coordinator Assistant.</p> <p>Resident #35: The bed was changed to Full Side rail bed 2/27/14 to reflect accuracy with the care plan. DON discussed full side rails Versus half side rails with the family to ensure this is what they still wanted.</p> <p>Resident #23: Care plan was updated to include additions intervention: Bed pad alarm and placing control box under bed where resident is unable to reach box to turn off. 2/27/14 by the MDS Coordinator Assistant.</p> <p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</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 02/26/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

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 280	<p>Continued From page 5 dated January 31, 2014, revealed no interventions to address the resident's use of the antianxiety and antidepressant medications.</p> <p>Interview on February 26, 2014, at 8:45 a.m., with the Director of Nursing (DON), in the DON's office, confirmed the Admission Care Plan did not address the use of the antianxiety and antidepressant medications.</p> <p>Resident #35 was admitted to the facility on November 1, 2013, with diagnoses including Fracture of Right Humerus (upper arm bone), Parkinson's, Osteoporosis, Hypertension, Non-Insulin Dependent Diabetes, and Dementia.</p> <p>Medical record review of the Admission Minimum Data Set dated November 14, 2013, revealed the resident used bed rails daily.</p> <p>Medical record review of the Care Plan dated November 14, 2013, revealed full side rails were ordered to prevent falls.</p> <p>Observation on February 26, 2014, at 12:15 p.m., revealed the resident had three quarter rails (bilateral upper and one lower) raised and one quarter rail (lower) down.</p> <p>Interview with the Director of Nursing on February 26, 2014, at 12:55 p.m., in the chapel, confirmed the care plan had not been updated to reflect the resident's use of three quarter bed rails.</p> <p>Resident #23 was admitted to the facility on December 11, 2012 with diagnoses including CVA (Cerebrovascular Accident) with Right Hemiparesis, Alzheimer's, Hypertension, and</p>	F 280	<p>Care plans were reviewed on all residents with restraints and falls by the care plan coordinator and assistant to ensure all interventions were included. Side rails were reviewed by MDS Assistant to ensure side rail usage was consistent with orders and recommendations. Care plans will also be reviewed by MDS Coordinator Assistant to ensure Psychotropic medications were care planned correctly. This will be complete by 3/31/14</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 by the DON on 3/12/14 to include the necessity of including psychoactive medications on the interim care plan. Interim Care Plan will by revised to include a section for these medications. Also will inform staff of the sections for behavior symptoms will need to have medications included. Also included is importance and necessity of interventions after each fall and the correct use of restraints as ordered.</p>	
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

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 02/26/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

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 280	<p>Continued From page 6 Osteoarthritis.</p> <p>Medical record review of the Minimum Data Set dated December 23, 2013, revealed the resident required extensive assistance for bed mobility, transfer, dressing, and toilet use. Further review, revealed the resident's balance during transitions and walking was unsteady and only able to stabilize with human assistance.</p> <p>Medical record review of the current Care Plan, revealed no documentation of additional interventions to address the resident's removal of the pressure pad alarm.</p> <p>Medical record review of the Licensed Nurses Notes dated January 26, 2014, revealed the resident was observed on the floor at the resident's bedside. The resident's pressure alarm pad was noted to be in the floor at bedside and not alarming. The resident was asked what happened to the pressure pad alarm and the resident "smiled" and said "I did that."</p> <p>Observation on February 26, 2014, at 7:15 a.m., revealed the resident in the bed with a pressure alarm pad underneath the resident's shoulders.</p> <p>Interview on February 25, 2014, at 2:30 p.m., in the Director of Nursing's (DON) office, with the DON and the MDS/CP (Minimum Data Set/Care Plan) Coordinator, revealed the new intervention for the fall occurring on January 26, 2014 was to place the safety pressure alarm pad further up the resident's body to attempt to prevent the resident from removing and turning the alarm off.</p> <p>Further interview with the DON confirmed the facility failed to update the care plan with the new</p>
-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

F 280	<p>New employees will be inserviced by reading the minutes of the staff meeting and signing/dating.</p> <p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? All completed restraint assessments will be kept on the "restraint info" book and kept at the nurses' desk. The book will be reviewed by the DON at least weekly and monitored by the QA committee monthly for 6 months. All new admission interim care plans will be reviewed by the DON and QA committee for completeness including monitoring for side effects and usage of psychotropic medications.</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 02/26/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

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)	(X6) COMPLETION DATE
<p>F 280</p> <p>F 282 SS=D</p>	<p>Continued From page 7 intervention following the resident's fall on January 26, 2014.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to implement the Care Plan for one resident (#18) of twenty-seven residents reviewed.</p> <p>The findings included:</p> <p>Resident #18 was readmitted to the facility on May 14, 2010, with diagnoses including Anxiety, Chronic Pain, Hypertension, Hyperlipidemia, and Osteoarthritis.</p> <p>Medical record review of the physician's recapitulation orders for February 2014, revealed the side rails were to be up/raised when the resident was in bed for positioning and mobility.</p> <p>Medical record review of a Side Rail Assessment dated May 14, 2010, revealed "...top 2 siderails for positioning..."</p> <p>Medical record review of the Care Plan reviewed on January 22, 2014, revealed "...1/2 side rails up when in bed to assist with bed mobility and prevent falls/injury..."</p>	<p>F 280</p> <p>F 282</p>	<p>F 282</p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>Resident #18: The Half side rails (top 2 rails) were discontinued from the care plan 3/5/14 New side rail assessment was completed on 3/5/14 and consent obtained by phone from POA on 3/5/14. Will continue with full side rails per MD order (monthly orders)</p> <p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>Charts of all residents who have side rails in use will be reviewed by 3/31/14 and new side rail assessments will be completed by 3/31/14 by the charge nurses.</p>	<p>3-3-14</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 02/26/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

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 282	<p>Continued From page 8</p> <p>Observation on February 24, 2014, at 9:58 a.m., revealed the resident lying on the bed with full length side rails bilaterally in the raised position.</p> <p>Observation on February 26, 2014, at 7:20 a.m., and 12:10 p.m., revealed the resident lying on the bed with bilateral full side rails in the raised position.</p> <p>Interview on February 25, 2014, at 12:50 a.m., with the Director of Nursing, in the conference room, confirmed the care plan was not followed for the side rails.</p>	F 282	<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 on 3/12/14 by the DON for nursing staff (RNs, LPNs and CNAs) to include instructions on use of restraint info book to include each resident with restraints and lap buddies. A list of these residents, a copy of assessments and consents and care plans will be included in the book. This will be completed by 3/31/14</p> <p>New employees will be inserviced by reading the minutes of the staff meeting and signing/dating.</p>	
F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to provide nail care for a dependent resident for one resident (#19) of three residents reviewed for Activities of Daily Living, of twenty-seven residents reviewed.</p> <p>The findings included: Resident #19 was admitted to the facility on April 22, 2010, with diagnoses including Traumatic Brain Injury, Hypertension, Anxiety, Depression,</p>	F 312	<p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>This book will be monitored by the DON at least weekly to ensure compliance and after each resident who will require a new or different restraint. QA committee will monitor monthly for 6 months.</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 02/26/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

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 282	Continued From page 8 Observation on February 24, 2014, at 9:58 a.m., revealed the resident lying on the bed with full length side rails bilaterally in the raised position. Observation on February 26, 2014, at 7:20 a.m., and 12:10 p.m., revealed the resident lying on the bed with bilateral full side rails in the raised position. Interview on February 25, 2014, at 12:50 a.m., with the Director of Nursing, in the conference room, confirmed the care plan was not followed for the side rails.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to provide nail care for a dependent resident for one resident (#19) of three residents reviewed for Activities of Daily Living, of twenty-seven residents reviewed. The findings included: Resident #19 was admitted to the facility on April 22, 2010, with diagnoses including Traumatic Brain Injury, Hypertension, Anxiety, Depression,	F 312	<p>F-312</p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>Resident #19: Nails were cleaned and trimmed by C.N.A. on 2/26/14 (afternoon)</p>	3-31-14

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 02/26/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

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 312	<p>Continued From page 9 Manic Bipolar.</p> <p>Review of the facility policy Nails, Care of (Finger and Toe), revealed "...Purpose...To provide cleanliness...to prevent spread of infection...for comfort...to prevent skin problems..."</p> <p>Observation and interview on February 25, 2014, at 9:15 a.m., with Licensed Practical Nurse #1 (LPN), in the resident's room, revealed the resident's nails extended approximately 1/4 inch beyond the nail bed with a brown substance under the nails. Interview at this time confirmed the nails needed to be trimmed and cleaned.</p>	F 312	<p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>All residents will be observed on their shower days by the charge nurses to ensure nail cleanliness and trimming.</p>	
F 323 SS=D	<p>Observation on February 26, 2014, at 12:00 noon, revealed the resident seated in a wheelchair, in the dining room. Continued observation revealed the resident's fingernails extending approximately 1/4 inch beyond the nail bed with a brown substance under the nails.</p> <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> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a safety device was functional for one (#10), failed</p>	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>Inservice on 3/12/14 by the DON to nursing staff (LPNs, RNs and CNAs) to include AM/PM care and nail care/hygiene.</p> <p>Staff was inserviced during huddle on 2/26/14 at 3pm for 7-3/3-11 shifts and 2/27/14 at 7am for 11-7/7-3 shift on proper care of fingernails and if needed giving this resident anti-anxiety prior to cleaning/trimming.</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 02/26/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

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 312	<p>Continued From page 9 Manic Bipolar.</p> <p>Review of the facility policy Nails; Care of (Finger and Toe), revealed "...Purpose...To provide cleanliness...to prevent spread of infection...for comfort...to prevent skin problems..."</p> <p>Observation and interview on February 25, 2014, at 9:15 a.m., with Licensed Practical Nurse #1 (LPN), in the resident's room, revealed the resident's nails extended approximately 1/4 inch beyond the nail bed with a brown substance under the nails. Interview at this time confirmed the nails needed to be trimmed and cleaned.</p> <p>Observation on February 26, 2014, at 12:00 noon, revealed the resident seated in a wheelchair, in the dining room. Continued observation revealed the resident's fingernails extending approximately 1/4 inch beyond the nail bed with a brown substance under the nails.</p>	F 312	<p>New employees will be inserviced by reading the minutes of the staff meeting and signing/dating.</p> <p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>Charge nurses will monitor nail care during showers and correct any non-compliance at that time, reporting (verbally) to the DON for any deviation for 1:1 counseling with employee. Will be reviewed in QA monthly 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> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a safety device was functional for one (#10), failed</p>	F 323	<p>F-323</p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>Resident #10: Pressure pad was replaced on 2/25/14 and tested to ensure proper working order.</p>	3-31-14

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 02/26/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

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 323 Continued From page 10
develop interventions after falls for one (#35) of three residents reviewed for accidents of twenty-seven residents reviewed.

The findings included:

Resident #10 was admitted to the facility on January 31, 2014, with diagnoses including Bladder Cancer, Hypertension, Diabetes, History of Chronic Obstructive Pulmonary Disease, History of Congestive Heart Failure, and Cerebrovascular Accident.

Medical record review of the admission Minimum Data Set dated February 13, 2014, revealed the resident scored a 15 on the Brief Interview for Mental Status indicating the resident was independent with daily decision making, required limited assistance of two persons for bed mobility, transfers, and walking, and had experienced a fall in the month prior to admission.

Medical record review of the Fall Risk Evaluation dated January 31, 2014, revealed the resident was at high risk for falls.

Medical record review of the Admission Care Plan dated January 31, 2014, revealed the resident was at risk for falls and a mobility alarm was applied.

Medical record review of a physician's order dated February 1, 2014, revealed "Bed/chair pressure alarm at all times."

Medical record review of a nursing note dated February 25, 2014, at 2:00 p.m., revealed "Resident found lying in bath tub by CNA (Certified Nursing Assistant). Resident stated 'I

F 323

Resident # 35: Fall were reviewed and inservice provided to staff (LPNs and CNAs) during huddle by the DON on 2/26/14 at 3pm for 7-3 and 3-11 shifts and also 2/27/14 at 7am for 7-3 and 11-7 shifts. Bed changed to full side rails after a discussion with family members to ensure continued request on 2/27/14 and to reflect correct care plan.

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

All residents with pressure pads or personal alarms were identified and all alarms were checked for proper working order on 2/26/14

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 02/26/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

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 323	<p>Continued From page 11</p> <p>was pulling my pants up and fell.' Was asked why...didn't turn the call light on resident stated 'I forgot.' Was reinforced to use call light when needing help, there are two pump knot, one on forehead & one on top of...head. c/o (complains of) pain where pump knot is, no other c/o (complains of) pain...CNA stated alarm was on but didn't go off. A note was placed in...room to remind...to use the call light when needing help.</p> <p>Observation on February 26, 2014, at 12:15 p.m., revealed the resident seated in a chair, in the resident's room with a pressure pad alarm in place.</p> <p>Interview on February 26, 2014, at 7:50 a.m., with Licensed Practical Nurse #1, in the medication room, confirmed the alarm did not sound at the time of the resident's fall on February 25, 2014. Continued interview revealed the pressure pad alarm had been replaced after the resident's fall, and it was unknown why the alarm did not sound. Continued interview revealed it was unknown when the pressure pad alarm was last checked for proper functioning.</p> <p>Interview on February 26, 2014, at 7:55 a.m., with CNA #1, (CNA who found the resident at the time of the fall on February 25, 2014), in the hallway, revealed the alarm was turned on at the time of the resident's fall, but did not sound.</p> <p>Interview on February 26, 2014, at 8:00 a.m., with the Director of Nursing (DON), in the DON's office, revealed the pressure pad alarms were checked to be in working order when first initiated, however, did not know if the alarms were checked for proper functioning after placement.</p>
-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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>Inservice to nursing staff (RNs, LPNs and CNAs) by the DON on 3/12/14 on checking alarms for proper working order daily. A section was added to the C.N.A. work sheet for alarms to be checked daily for proper working order beginning 2/26/14</p> <p>This was inserviced to staff during huddles on 2/26/14 3pm (for 1st and 2nd shifts) and 2/27/14 7am for 1st and 3rd shifts)</p> <p>This will be the responsibility of 7-3 C.N.A.s</p> <p>New employees will be inserviced by reading the minutes of the staff meeting and signing/dating.</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 02/26/2014
--------------------------------------------------	-------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

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 323	<p>Continued From page 12</p> <p>Resident #35 was admitted to the facility on November 1, 2013 with diagnoses including Fracture of Right Humerus (upper arm bone), Parkinson's, Osteoporosis, Hypertension, Non-insulin Dependent Diabetes, and Dementia.</p> <p>Observation on February 26, 2014, at 8:40 a.m. revealed the resident in a wheelchair with a chair alarm pad in the seat of the wheelchair.</p> <p>Medical record review of the Admission Minimum Data Set dated November 14, 2013, revealed the resident required extensive assistance for bed mobility, transfer, walking, dressing, and toilet use. Further review; revealed the resident's balance during transitions and walking was not steady and only able to stabilize with human assistance.</p> <p>Medical record review of the Care Plan dated November 14, 2013, revealed the resident at risk for recurrent falls with interventions including "...keep call light in reach...fall precautions...pressure pad alarm in bed and w/c (wheelchair)...put ... (the resident) in recliner after dinner (2/11/14)..."</p> <p>Medical record review of the facility's fall tracking revealed falls occurring on December 16, 2013, January 10, 2014, and February 11, 2014.</p> <p>Interview on February 26, 2014, at 8:40 a.m., in the chapel; with the DON (Director of Nursing), revealed after the fall on December 16, 2013, the facility reminded the resident to ask for assistance and to use the call light. Further interview with the DON confirmed no new interventions were put into place for the falls</p>	F 323	<p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>DON will monitor for compliance at least weekly. Will report to QA committee monthly for 6 month. Fall reports will be monitored by the DON for approp. interventions put into place after fall. QA committee will monitor monthly for 6 months.</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 02/26/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

<p>F 323</p> <p>F 325 SS=D</p>	<p>Continued From page 13 occurring on December 16, 2013 and January 10, 2014. The DON stated, "I would have expected on the second one (fall) they (the facility) would have done something else."</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review, facility policy review, observation, and interview, the facility failed to follow the facility policy for weight loss for one resident with weight loss (#49), of three residents reviewed for weight loss of twenty-seven residents reviewed.</p> <p>The findings included:</p> <p>Resident #49 was admitted to the facility on January 31, 2013, with diagnoses including Dementia, Diabetes, Depression, and Hypertension. The resident was discharged on April 2, 2013.</p> <p>Medical record review of the weight control record</p>	<p>F 323</p> <p>F 325</p>	<p>F 325</p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>Resident #49 has been discharged, therefore no corrective action could be taken.</p> <p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>All residents were weighted in 3/6/14 for monthly weights. These weights were reviewed by the DON and also by the FSS for inclusion in weekly weights.</p>	<p>3-31-14</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 02/26/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

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 325	<p>Continued From page 14</p> <p>revealed the following weights: January 31, 2013-187 pounds February 6, 2013-182 pounds February 13, 2013-182 pounds February 20, 2013-182 pounds February 27, 2013-188 pounds March 6, 2013-175 pounds</p> <p>Medical record review of the weight record revealed the resident had a thirteen pound weight loss from February 27, 2013, to March 6, 2013. Continued review revealed weekly weights were not documented after March 6, 2013.</p> <p>Medical record review of the Medical Nutrition Therapy Assessment dated February 7, 2013, revealed "...Admit wt. (weight) 187...DBW (Desired Body Weight) 170-210...feeds self after tray set up..."</p> <p>Medical record review of the Licensed Nurses Notes dated February 7, 2013, revealed "...Feeds self (with) tray set up ate in (dining) room..."</p> <p>Medical record review of the (Dietary) Progress Notes dated March 5, 2013, revealed "...Resident adjusting well to facility. Able to make needs known. Diet continues to be CCHO (Consistent Carbohydrate Diet), cut up (meats). PO (by mouth) intake is 50-75%. Will continue to monitor PO intake and weight..."</p> <p>Medical record review of the flow sheets for diet intake dated February, and March, 2013, revealed the resident's diet intake ranged from 50% to 100%.</p> <p>Review of the facility policy, "Weight Assessments", revealed "...All residents will be</p>	F 325	<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 by the DON on 3/12/14 to nursing Staff (RNs, LPNs and CNAs) included policy for weights, re-weighs and weekly weights.</p> <p>FSS will notify physician with any recommendation for weight loss.</p> <p>Charge nurses will notify physician for any weight loss over 5 pounds monthly or each time resident is weighed. C.N.A.'s will notify change nurse of a 5 pound or greater weight loss each time resident is weighed.</p> <p>New employees will be inserviced by reading the minutes of the staff meeting and signing/dating.</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 02/26/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

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 325	Continued From page 15 weighed at least monthly and more often if indicated...Residents who have experienced a significant weight loss should be weighed weekly until weight stabilizes..." Interview on February 25, 2014, at 1:40 p.m., with the Director of Nursing (DON), in the conference room, confirmed the resident had significant weight loss from February 27, 2013 to March 6, 2013. Continued interview confirmed weekly weights had not been completed after March 6, 2013. Interview on February 26, 2014, at 7:30 a.m., with the resident's physician, in the conference room, confirmed would have asked for the resident to be reweighed with a weight loss of 13 pounds in one week. Further interview confirmed would question if weight was accurate. Interview on February 26, 2014, at 11:00 a.m., with the DON, in the conference room, revealed the resident had a built up shoe and was not sure if weighed with or without the shoe on, felt the weight of 188 was inaccurate. Continued interview confirmed the resident was reweighed at 175 pounds on March 6, 2013, and weekly weights had not been obtained.	F 325	4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? DON and FSS to review monthly as well as weekly weights to ensure compliance. QA committee will monitor monthly for 6 months	
F 329 SS=D	C/O #31451 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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	F 329	F 329 1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?	3-31-14

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0381

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 02/26/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

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 329	<p>Continued From page 16</p> <p>indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of a pharmacy communication form, medical record review, observation, and interview, the facility failed to ensure one resident (#4) did not receive an unnecessary medication of five residents reviewed for unnecessary medications of twenty-seven residents reviewed.</p> <p>The findings included:</p> <p>Resident #4 was admitted to the facility on January 27, 2010, with diagnoses including Congestive Heart Failure, Hypertension, Chronic Pain, Constipation, Coronary Artery Disease, Dementia, and Atrial Fibrillation.</p> <p>Review of a Physicians Communication Form,</p>	F 329	<p>Resident #4: Medication was discontinued with no adverse effects in delay.</p> <p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>During the next month's (March) pharmacy review, all residents for physician recommendations will be immediately faxed to physician(s) and call placed to physician(s) to respond to recommendations.</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>DON will speak to physicians regarding the importance of acting timely on Pharmacist recommendations by 3/31/14) Recommendations will be faxes and calls placed after faxing until response is met.</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 02/26/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

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 329	<p>Continued From page 17 from the pharmacist, dated July 25, 2013, revealed "...Anti-psychotic Quetiapine (Seroquel) 25 mg (milligrams) w/o (without) documentation of a specific diagnosis and benefit to the resident..."</p> <p>Medical record review of the July 2013, physician's recapitulation orders revealed "...Quetiapine...25 mg (milligrams), take 1/2 tablet at bedtime..."</p> <p>Medical record review revealed no documentation the physician was notified of the pharmacy recommendation until August 21, 2013, when an order was obtained to discontinue the Seroquel.</p> <p>Observation on February 24, 2014, at 9:53 a.m., revealed the resident seated in a recliner, in the resident's room, with an alarm in place.</p> <p>Interview on February 25, 2014, at 3:05 p.m., with the Director of Nursing, in the conference room, confirmed there was a delay in notifying the physician of the pharmacy recommendation, and the resident received the Quetiapine until August 21, 2013.</p>	F 329	<p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>QA committee will monitor for timeliness for 6 months.</p>	
F 428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p>	F 428	<p>F -428</p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>Resident #4: medication was discontinued on 8/21/13 without any adverse effects caused by delay.</p>	3-31-14

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 02/26/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

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 428	<p>Continued From page 18</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of a pharmacy communication form, medical record review, and interview, the facility failed to timely notify the physician of pharmacy communication for one resident (#4) of five residents reviewed for unnecessary medications of twenty-seven residents reviewed.</p> <p>The findings included:</p> <p>Resident #4 was admitted to the facility on January 27, 2010, with diagnoses including Congestive Heart Failure, Hypertension, Chronic Pain, Constipation, Coronary Artery Disease, Dementia, and Atrial Fibrillation.</p> <p>Medical record review of the July 2013, physician's recapitulation orders revealed "...Quetiapine(Seroquel)...25 mg (milligrams) take 1/2 tablet at bedtime..."</p> <p>Review of a Physicians Communication Form, from the pharmacist, dated July 25, 2013, revealed "...Anti-psychotic Quetiapine (antipsychotic)...25 mg (milligrams) w/o (without) documentation of a specific diagnosis and benefit to the resident..."</p> <p>Medical record review revealed no documentation the physician was notified of the pharmacy recommendation until August 21, 2013, when an order was obtained to discontinue the Seroquel.</p> <p>Interview on February 25, 2014, at 3:05 p.m., with the Director of Nursing, in the conference room,</p>	F 428	<p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>With the next month's pharmacy review (March), all residents that have recommendations will be faxed to the physician(s) and call placed to physician(s) to respond to recommendation.</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>DON will speak to the physicians, by 3/31/14, regarding their timely response to recommendations made by the pharmacist. Recommendations will be faxes or emailed and phone calls placed to physician by DON until response to recommendation is met.</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 02/26/2014
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

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 428	Continued From page 19 confirmed there was a delay in notifying the physician of the pharmacy recommendation.	F 428	<p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>QA committee will monitor for timeliness monthly for 6 months.</p>	
-------	---------------------------------------------------------------------------------------------------------------	-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--