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

45th 11/21/15

PRINTED: 10/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445244		10/07/2015

NAME OF PROVIDER OR SUPPLIER: LIFE CARE CENTER OF CLEVELAND

STREET ADDRESS, CITY, STATE, ZIP CODE: 3530 KEITH ST NW, CLEVELAND, TN 37311

(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 A Recertification survey and complaint investigation #37250 were conducted from October 10/5/15, through 10/7/15, at Life Care Center of Cleveland. No deficiencies were cited in relation to the complaint under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000	Preparation, submission and implementation of this Plan of Correction do not constitute an admission of or agreement with the facts on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and comply with all applicable State and Federal Regulatory Requirements.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow physician's order for discontinuing a medication for 1 resident (#107) of 5 residents reviewed for unnecessary medications, of 33 sampled residents. The findings included: Medical record review revealed Resident #107 was admitted to the facility on 8/25/14 with diagnoses including Cerebrovascular Disease, Major Depressive Disorder, Hypertension, Diabetes Mellitus Type 2, and Hemiplegia. Medical record review of the pharmacy Consultation Report dated 8/5/15 revealed "... [Resident #107] receives Methocarbamol [muscle	F 309	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Upon record review and interview, the facility failed to follow physician order to discontinue a medication for 1 resident (#107). On 10/2/15 the Robaxin was discontinued. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** On 10/7/15 the nursing administration team conducted a 100% audit on the pharmacy recommendations for August, September, and October, 2015. No further errors were found during the audit. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and** On 10/7/15 the Director of Nursing wrote a Performance Improvement Plan that included a best practice for the processing of pharmacy recommendations. The nursing administration team and the physician's team, and Omnicare pharmacist were educated on the process on 10/7/15. The Staff nurses will be educated on the process via our Hot Topics Monthly Education and at the Mandatory Nurses Meeting on November 5, 2015. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The Director of Nursing or designee will monitor the Pharmacy Recommendations log monthly and report her findings to the PI committee for 3 months.	11/21/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature], LNHA — TITLE: Executive Director — (X6) DATE: 10/28/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	Continued From page 1 relaxer] 750 mg [milligrams] q [every] 6 h [hours] prn [as needed], a high risk medication due to strong, sedating, anticholinergic properties [dry mouth, blurred vision, sedation, urinary retention, tachycardia, and toxic psychosis], increased risk for fracture and questionable efficacy at doses tolerated by the elderly..." Continued review revealed "...please consider discontinuing Methocarbamol and initiating tizanidine [muscle relaxer] 4 mg prn..." Further review revealed the physician signed, dated, and approved the recommendation "...please implement as written..." on 8/6/15. Medical record review of Medication Administration Records (MARs) for the months of August and September 2015 revealed the MARs had both the Methocarbamol and tizanidine listed on the MARs, and the Methocarbamol had not been discontinued as ordered by the physician. Medical record review of a pharmacy Consultation Report dated 10/1/15 revealed, "... [Resident #107] has an order for Methocarbamol prn that is still on the MAR after a recommendation to discontinue was accepted by MD [medical doctor]...please clarify the current status of this order and notify the pharmacy to prevent medication errors and update medical records..." Further review revealed a handwritten note by the resident's physician the medication was discontinued on the MAR on 10/2/15. Interview with the Director of Nurses (DON) on 10/6/15 at 4:32 PM, in the Staff Development Office, confirmed the facility failed to discontinue a medication as ordered by the physician.	F 309		
F 371	483.35(i) FOOD PROCURE,	F 371		

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F 371 SS=F	Continued From page 2 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food preparation equipment was sanitary. The findings included: Observation with the Dietary Manager (DM), on 10/5/15, from 9:50 AM, to 10:20 AM, in the dietary food preparation area, revealed: dried brown debris on 2 small cookie sheets; clear tape on 1 washed and dried large cookie sheet; 2 drip pans under the stove burners had burnt debris; the deep fryer had oily brown debris floating on the oil and on the sides of the deep fryer and on the appliances next to the deep fryer. Continued observation revealed the convection oven had debris on the bottom of inside the oven, the salad bar had dried debris on the surrounding stainless steel, and the manual can opener had black debris on the blade holder. Interview with the DM on 10/5/15, during the observation from 9:50 AM, to 10:20 AM, confirmed the debris on the cookie sheets, the	F 371	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Upon observation of the dietary area several items were found to have dried food /debris on them. Immediately 3 cookie sheets were discarded and the deep fryer, the convection oven, the salad bar and the can opener were all cleaned. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** On 10/5/15 the Certified Dietary Manager inspected the entire dietary department for additional unclean items, no further issues were found. The staff were also educated that day (100%) for the cleaning schedule and their role. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and** The cooks are responsible to complete the Cooks Audit Sheet every shift which includes the cleaning schedule. This will be an ongoing process in the department. The Certified Dietary Manager or designee complete a Dietary Managers Checklist which includes the cleaning schedule weekly. This will be an ongoing process in the department. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The Certified Dietary Manager will report monthly to the Performance Improvement Committee as an ongoing process.	11/21/15

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F 371	Continued From page 3 stove drip pans, the debris in and around the deep fryer, the debris within the convection oven, on the stainless steel around the salad bar, and on the manual can opener. Continued interview confirmed the facility failed to ensure food preparation equipment was sanitary.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Upon observation of the medication storage room on skilled wing, 4 bottles of Nepro Tube Feeding were expired, immediately these bottles were discarded and the Unit Coordinator did a complete check of this area to ensure there were no further expired items. Upon observation of the medication storage room on East wing, 1 unopened bottle of 100 vitamin B-6 tables expired, the Unit Coordinator immediately discarded them and did a complete check of this area to ensure there were no further expired items. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** On 10/7/15 the South Wing Unit Coordinator did a complete check of the South Wing medication storage room to ensure there were no expired items, no discrepancies were found. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and** The Unit Coordinators will do a complete check weekly beginning 10/27/2015 to ensure there are no expired items stored and ready for resident use in the medication rooms. The Unit Coordinators will continue the weekly checks for 4 weeks, then check monthly for 3 months to ensure we have a no expired items stored in the medication rooms for resident use.	11/21/15

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F 431	Continued From page 4 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure expired medications were properly disposed of in 2 of 3 medication rooms observed. The findings included: Observation with Licensed Practical Nurse (LPN) #1, on 10/7/15, at 8:46 AM, of the Skilled hall medication room, revealed the following expired medication stored in the over the counter cabinet: 4 bottles of 1 liter 180 cal/liter Nepro tube feeding solution, expired 10/1/15. Observation with LPN #2, on 10/7/15 at 8:58 AM, of the East hall medication room, revealed 1 unopened bottle of 100 vitamin B-6 tablets, 50 mg (milligrams) each, expired 9/2015. Interview with LPN #1, on 10/7/15, at 8:46 AM, in the Skilled hall medication room, confirmed the tube feedings were expired and available for resident use. Interview with LPN #2, on 10/7/15, at 8:58 AM, in the East hall medication room, confirmed the bottle of vitamin B-6 tablets were expired and available for resident use.	F 431	How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. The Unit coordinators will report weekly in the nursing administration meeting of any discrepancies found. The Director of Nursing will report monthly to the Performance Improvement Committee for six months.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 5 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Upon observation of the LPN #3, and review of the facilities Injection Administration Policy the nurse failed to use gloves during an injection to resident # 179. This nurse was immediately given corrective action and education regarding the use of gloves during medication administration. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** On 10/6/15 100% education was provided to the nursing staff to ensure everyone understood the policy regarding glove use during medication administration. This policy will also be reviewed at the Mandatory Nurses meeting on November 5, 2015. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and** The Staff Development Coordinator will conduct random observations on all shifts during medication administration via injections. She will conduct 3 each week for 4 weeks, and then 1 weekly for 3 months. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The Staff Development Coordinator will report weekly in the nursing administration meeting of any discrepancies found. The Staff Development Coordinator will report monthly to the Performance Improvement Committee for four months.	11/21/15

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F 441	Continued From page 6 Based on review of facility policy, medical record review, observation and interview, the facility failed to follow standard infection control practices related to failure to wear personal protective equipment during an injection for 1 resident (#179), of 3 residents who were observed receiving an injection, of 5 residents who were observed during the medication pass observation. The findings included: Review of the facility policy "Injection" with no date revealed "...general infection control guidelines...(1) observe standard universal precautions or other infection control standards as approved by appropriate facility committee... (2)wash your hands before and after all procedures...wear gloves when appropriate..." Medical record review revealed Resident #179 was readmitted to the facility on 8/7/15 with diagnoses including Dementia, Hypertension, Anemia, Gastroesophageal Reflux, Pain, and Type 2 Diabetes Mellitus with Hyperglycemia. Observation with Licensed Practical Nurse (LPN) #3 on 10/6/15 at 9:40 AM, in Resident #179's room, revealed LPN #3 prepared to give an injection to Resident #179. Continued observation revealed the nurse administered the injection without doning gloves prior to the injection. Further observation revealed after the injection was completed there was blood at the injection site and the LPN wiped the site with an alcohol wipe with no gloves on the hands. Further observation revealed the nurse disposed of the alcohol wipe in the trash can and placed the contaminated needle in the needle box with no gloves on the hands.	F 441		

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F 441	Continued From page 7 Interview with LPN #3 on 10/6/15, at 9:45 AM, in the South Wing Hallway, confirmed LPN #3 did not wear personal protective equipment while administering the injection. Further interview confirmed the nurse did not follow the facility's policy. Interview with the Director of Nursing (DON) on 10/6/15 at 10:00 AM, in the DON's office, confirmed LPN #3 had failed to follow the facility's policy regarding the wearing of personal protective equipment. Interview with Registered Nurse (RN) #1, who is the Infection Control Preventionist (ICP) for the facility, on 10/7/15 at 10:30 AM, in the ICP office, confirmed staff should wear gloves when administering an injection and the nurse failed to follow the facility's policy.	F 441		