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OMB NO. 0938-0391

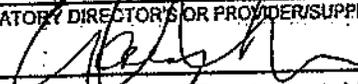
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445339	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2011
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NAME OF PROVIDER OR SUPPLIER BAILEY PARK CLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MITCHELL STREET HUMBOLDT, TN 38343
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observations and an interview, it was determined 1 of 4 (Nurse #1) nurses administering medications failed to maintain privacy and confidentiality of the resident's medical records by leaving the Medication Administration Record (MAR)</p>	F 164	<p>This Plan of Correction is being submitted as required by Federal Regulations. The submission of this plan of correction is not to be construed as an admission by the facility as to the accuracy of the citation nor the findings of facts. Please accept this as our plan of correction.</p>	2/4/11
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 2/4/11
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acceptable POC 2/4/11 JPP/HNK 2

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 164 SS-D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution, or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution, law, third party payment contract, or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observations and an interview, it was determined 1 of 4 (Nurse #1) nurses administering medications failed to maintain privacy and confidentiality of the resident's medical records by leaving the Medication Administration Record (MAR)</p>	F 164	<p>F 164</p> <ol style="list-style-type: none"> 1. Nurse #1 was re-educated by the DON on 2-1-11, regarding closing the MAR when left unattended. 2. The DON observed the remaining medication nurses during medication pass by 2-4-11 to identify others with the potential to be affected. No other nurses were noted to leave the MAR open unattended. 3. Licensed nursing staff were inserviced regarding the resident rights to personal privacy and confidentiality of records on 2-1-11 by the DON. Newly hired nurses will be educated regarding privacy and annually. 	2/20/11

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F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observations and an interview, it was determined 1 of 4 (Nurse #1) nurses administering medications failed to maintain privacy and confidentiality of the resident's medical records by leaving the Medication Administration Record (MAR)</p>	F 164	<p>4. The DON or RN supervisor will observe a medication pass with one nurse each shift every week for 4 weeks. The nurse consultant will review a minimum of monthly x 3 months.. Findings of the medication pass audit r/t privacy and confidentiality of records will be reported to the QA committee monthly for the next 12 months and as needed. The QA committee consist of: Administrator, DON, MD, DM, SS, Act, MDS nurse and medical records nurse and others.</p>	

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F 164	Continued From page 1 uncovered with resident information visible. The findings included: Review of the facility's "SPECIFIC PROCEDURES FOR ALL MEDICATIONS" policy documented, "...Secure records containing protected health information... Medication Administration Records (MARS)..." Observations on the 100 hall on 1/19/11 at 7:10 AM, Nurse #1 left the MAR opened and unattended with a resident's information visible. Observations on the 300 hall on 1/19/11 at 8:15 AM, 8:38 AM, 8:55 AM, 9:20 AM, 9:23 AM, 9:28 AM, 9:28 AM and 9:30 AM, Nurse #1 left the MAR opened and unattended with a resident's information visible. During an interview at the nurses station on 1/20/11 beginning at 12:45 PM, the Director of Nursing (DON) was asked if it was acceptable for resident information to be visible to anyone who passed by. The DON stated, "No."	F 164		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280		

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F 280	<p>Continued From page 2</p> <p>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 policy review, medical record reviews, observation and interviews, it was determined the facility failed to revise the comprehensive care plan to reflect the current status of residents for seizure precautions, anticoagulant therapy or feeding precautions for 4 of 13 (Resident #1, 2, 7 and 8) sampled residents.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's, "Care Plans - Comprehensive" policy documented, "...b. Incorporate risk factors associated with identified problems... 4. Care plans revised as changes in the resident's conditions dictates. Reviews are made at least quarterly..." 2. Medical record review for Resident #1 documented an admission date of 1/30/06 with readmission date of 9/30/10 with diagnoses of Hypotension, Urinary Tract Infection, Difficulty In Walking, Edema, Hypertension, Diabetes, Mental Retardation and Schizophrenia. Review of the physician's orders dated for 1/3/11 documented, "...VALPROATE SODIUM 250 MG [milligrams] / [per] 5 ML [milliliters] VIA PEG [Percutaneous 	F 280	<p>F280</p> <ol style="list-style-type: none"> 1. The Care plan for resident #1 has been revised to include seizure precautions on 1-20-11. The care plan for resident #2 has been revised to include emergency measures for bleeding and Coumadin therapy on 1-20-11. The care plan for resident #7 has been revised to include special instructions for feeding on 1-20-11. The care plan for resident #8 has been revised to include emergency measures for bleeding and anticoagulant therapy on 1-20-11. 2. The DON and MDS coordinator will review all care plans specific for seizure activity, emergency measures for bleeding and Coumadin therapy, specific instructions for bleeding by 2-15-11. 	2/20/11

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F 280	<p>Continued From page 2</p> <p>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 policy review, medical record reviews, observation and interviews, it was determined the facility failed to revise the comprehensive care plan to reflect the current status of residents for seizure precautions, anticoagulant therapy or feeding precautions for 4 of 13 (Resident #1, 2, 7 and 8) sampled residents.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's, "Care Plans - Comprehensive" policy documented, "...b. incorporate risk factors associated with identified problems... 4. Care plans revised as changes in the resident's conditions dictates. Reviews are made at least quarterly..." 2. Medical record review for Resident #1 documented an admission date of 1/30/06 with readmission date of 9/30/10 with diagnoses of Hypotension, Urinary Tract Infection, Difficulty In Walking, Edema, Hypertension, Diabetes, Mental Retardation and Schizophrenia. Review of the physician's orders dated for 1/3/11 documented. "...VALPROATE SODIUM 250 MG [milligrams] / [per] 5 ML [milliliters] VIA PEG [Percutaneous 	F 280	<p>3. The care plan team was inserviced regarding providing a comprehensive care plan on for each resident on 2-1-11 by the DON .</p> <p>4. The monitoring of care plans implementation will be done weekly by the MDS coordinator for 4 weeks, then monthly for 1 month and then quarterly for next 12 months. Findings will be reported to the QA committee monthly for 1 month and then quarterly for next 12 months. The QA committee consist of ADM, DON, MR, FS, Pharmacy, SS, ACT, environmental services, MDS coordinator and others.</p>	
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F 280	<p>Continued From page 3</p> <p>Endoscopy Gastrostomy] TUBE Q [every] 12 HOURS FOR SEIZURES... * Review of the care plan updated on 1/12/11 had no documentation for seizure precautions.</p> <p>During an interview in the conference room on 1/20/11 at 9:35 AM, the Minimum Data Set (MDS) nurse confirmed there was no care plan for seizure precautions.</p> <p>2. Medical record review for Resident #2 documented an admission date of 2/26/09 with diagnoses of Diabetes Mellitus, Cerebrovascular Accident with Right Hemiplegia, Hypertension and Dementia. Review of the recertification orders dated 10/13/10 documented, "...Coumadin 4 mg tablet 1 po [by mouth] daily at 5 PM..." Review of the care plan dated 11/17/10 had no documentation for anticoagulant therapy.</p> <p>During an interview in the conference room on 1/20/11 at 10:00 AM, the MDS coordinator reviewed the care plan dated 11/17/10 and stated, "...I don't see anything on anticoagulant therapy..."</p> <p>3. Medical record review for Resident #7 documented an admission date of 4/30/10 and a readmission date of 10/15/10 with diagnoses of Meningioma, Obesity, Dementia, Oral Dysphagia, Gastroesophageal Reflux Disease and Personality Change Due to Brain Tumor. Review of the comprehensive care plan dated 10/23/10 documented, "...Self-care deficit... Assist with meals as needed-CNA [Certified Nursing Assistant]..." Review of the physician's order dated 1/12/11 documented, "...FEEDING PRECAUTIONS: SMALL SIPS, SIT UPRIGHT, ASSISTANCE WITH MEALS AS NEEDED,</p>	F 280		

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F 280	Continued From page 4 ALTERNATE BITES WITH SIPS... Observation in the dining room on 1/18/11 at 11:55 AM revealed, CNA #1 gave 6 bites of food to Resident #7 before offering liquid. During an interview in the conference room on 1/19/11 at 4:40 PM, CNA #5 was asked about any special instructions on how to assist Resident #7 with meals. CNA #5 stated, "...prop him up with pillows in his wheelchair... if he is lying over to his side be sure to keep him up..." 4. Medical record review for Resident #8 documented an admission date of 1/28/09 with a readmission date of 3/30/09 with diagnoses of Lower Extremity Embolism, Muscle Atrophy, Depression, Diabetes Malignant Hypertension and End Stage Renal Disease. Review of the physician orders dated 10/22/10 documented "...Coumadin 9.5 MG 1 PO DAILY..." Review of the care plan updated 8/10 revealed no documentation for anticoagulation therapy. During an interview in the conference room on 1/20/11 at 9:10 AM, the MDS Nurse reviewed the care plan and confirmed that anticoagulation therapy was not on the care plan for Resident #8.	F 280			
F 282 SS-B	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by:	F 282	F282 1. Resident #1 now has a hand roll in the left hand. Resident #4 now has the bed against the wall. Resident #7 bed/chair alarm and motion detector in the bathroom have been d/c'ed.	2/20/11	

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F 282	<p>Continued From page 5</p> <p>Based on medical record reviews, observations and interviews, it was determined the facility failed to follow interventions for hand rolls, positioning the bed against the wall, use of bed or chair alarms or use of motion detector in a bathroom on the comprehensive care plan for 3 of 13 (Residents 1, 4 and 7) sampled residents.</p> <p>The findings included:</p> <p>1. Medical record review for Resident #1 documented an admission date of 1/30/06 with readmission date of 9/30/10 with diagnoses of Hypotension, Urinary Tract Infection, Difficulty in Walking, Edema, Hypertension, Diabetes, Mental Retardation and Schizophrenia. Review of the care plan updated 1/12/11 documented, "hand roll to (L) [left] hand as tolerated per O.T [Occupational Therapy]..."</p> <p>Observations in Resident #1's room on 1/18/11 at 9:30 AM, 11:45 AM, 2:30 PM and 3:25 PM, on 1/19/11 at 7:05 AM, 7:30 AM and 11:10 AM and on 1/20/11 at 8:15 AM, revealed Resident #1 lying in bed with no hand roll in her left hand as care planned.</p> <p>During an interview in the conference room on 1/20/11 at 2:00 PM, the Director of Nurses confirmed that Resident #1 should have a hand roll in her left hand.</p> <p>2. Medical record review for Resident #4 documented an admission date of 9/2/09 with current diagnoses of Presenile Depression and Hypertension. Review of the care plan updated 1/12/11 documented that the resident had a history of falls with an intervention to keep "...Bed against wall..."</p>	F 282	<p>2. The DON and MDS coordinator will review resident care plans for implementation of hand rolls, bed placement, bed/chair alarms, motion detector and alert staff for updates by 2-15-11.</p> <p>3. Care Plan update information will be placed in acu-nurse, ie: hand rolls, bed positioning, bed/chair alarms. Nursing staff was inserviced on 2-1-11 in reference to following the plan of care by the DON and MDS coordinator.</p> <p>4. The monitoring of care plan implementation will be done weekly by the MDS coordinator for 4 weeks then monthly for 1 month and then quarterly for the next 12 months. Findings will be reported to the QA committee monthly for 1 month and then quarterly for the next 12 months. The QA committee consist of : adm, DON, MR, FS,</p>	

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F 282	<p>Continued From page 5</p> <p>Based on medical record reviews, observations and interviews, it was determined the facility failed to follow interventions for hand rolls, positioning the bed against the wall, use of bed or chair alarms or use of motion detector in a bathroom on the comprehensive care plan for 3 of 13 (Residents 1, 4 and 7) sampled residents.</p> <p>The findings included:</p> <p>1. Medical record review for Resident #1 documented an admission date of 11/30/06 with readmission date of 9/30/10 with diagnoses of Hypotension, Urinary Tract Infection, Difficulty in Walking, Edema, Hypertension, Diabetes, Mental Retardation and Schizophrenia. Review of the care plan updated 1/12/11 documented, "hand roll to (L) [left] hand as tolerated per O.T [Occupational Therapy]..."</p> <p>Observations in Resident #1's room on 1/18/11 at 9:30 AM, 11:45 AM, 2:30 PM and 3:25 PM, on 1/19/11 at 7:05 AM, 7:30 AM and 11:10 AM and on 1/20/11 at 8:15 AM, revealed Resident #1 lying in bed with no hand roll in her left hand as care planned.</p> <p>During an interview in the conference room on 1/20/11 at 2:00 PM, the Director of Nurses confirmed that Resident #1 should have a hand roll in her left hand.</p> <p>2. Medical record review for Resident #4 documented an admission date of 9/2/09 with current diagnoses of Presenile Depression and Hypertension. Review of the care plan updated 1/12/11 documented that the resident had a history of falls with an intervention to keep "...Bed against wall..."</p>	F 282	Pharmacy, SS, ACT, environmental services, MDS coordinator and others.	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445339	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/20/2011
NAME OF PROVIDER OR SUPPLIER BAILEY PARK CLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MITCHELL STREET HUMBOLDT, TN 38349		
(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 6</p> <p>Observations in Resident #4's room on 1/18/11 at 12:10 PM and 2:20 PM, revealed Resident #4 lying in bed. Resident #4's bed was not against the wall as care planned.</p> <p>During an interview in Resident #4's room on 1/20/11 at 8:45 AM, Nurse #5 stated "...could not state that bed was against the wall..."</p> <p>3. Medical record review for Resident #7 documented an admission date of 4/30/10 and a readmission date of 10/16/10 with diagnoses of Menigitoma, Obesity, Dementia, Oral Dysphagia, Gastroesophageal Reflux Disease and Personality Change Due to Brain Tumor. Review of the comprehensive care plan dated 10/23/10 documented, "...Risk for injury r/t [related to] falls... Bed alarm WJB [while in bed] / chair alarm... Motion Detector alarm in bathroom..."</p> <p>Observations in the dining room on 1/18/11 at 11:41 AM and on 1/19/11 at 7:40 AM, revealed Resident #7 sitting in a wheelchair with no chair alarm in place as care planned.</p> <p>Observations in Resident #7's room on 1/19/11 at 11:10 AM, revealed Resident #7 lying in bed with no bed alarm on the bed as care planned.</p> <p>Observations in Resident #7's bathroom on 1/19/11 at 11:12 AM, revealed the motion detector was not on as care planned.</p> <p>During an interview in Resident #7's room on 1/19/11 at 4:40 PM, Certified Nursing Assistant (CNA) #5 verified that Resident #7 did not have a bed or chair alarm. CNA #5 turned on the motion detector in Resident #7's bathroom during this</p>	F 282			

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NAME OF PROVIDER OR SUPPLIER BAILEY PARK CLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MITCHELL STREET HUMBOLDT, TN 38343
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F 282	Continued From page 7 interview.	F 282		
F 309 SS-D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined the facility failed to ensure physician's orders were followed for feeding precautions and fall interventions for 1 of 13 (Resident #7) sampled residents.</p> <p>The findings included:</p> <p>Medical record review for Resident #7 documented an admission date of 4/30/10 and a readmission date of 10/15/10 with diagnoses of Meningioma, Obesity, Dementia, Oral Dysphagia, Gastroesophageal Reflux Disease and Personality Change Due to Brain Tumor. Review of the physician's order dated 1/12/11 documented, "...FEEDING PRECAUTIONS: SMALL SIPS, SIT UPRIGHT, ASSISTANCE WITH MEALS AS NEEDED, ALTERNATE BITES WITH SIPS... BODY / BED ALARM WHILE IN BED / WHEELCHAIR..."</p> <p>Observations in the dining room on 1/18/11 at 11:55 AM, Certified Nursing Assistant (CNA) #1 gave 6 bites of food to Resident #7 before</p>	F 309	<p>F309</p> <ol style="list-style-type: none"> 1. CNA #1 has been serviced on 2-1-11 regarding specific feeding instructions for resident #7. Resident #7's chair/bed alarm has been d/c'ed. 2. The DON and care plan coordinator will review resident physician's orders r/t feeding instructions, fall intervention by 2-15-11 and update information will be placed in the accu-nurse system. 3. Nursing staff was inserviced on 2-1-11 regarding following Physician's orders with special feeding instructions and fall intervention by the DON. 	2/26/11

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NAME OF PROVIDER OR SUPPLIER BAILEY PARK CLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MITCHELL STREET HUMBOLDT, TN 38343
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F 282 F 309 SS=D	<p>Continued From page 7 interview.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined the facility failed to ensure physician's orders were followed for feeding precautions and fall interventions for 1 of 13 (Resident #7) sampled residents.</p> <p>The findings included:</p> <p>Medical record review for Resident #7 documented an admission date of 4/30/10 and a readmission date of 10/15/10 with diagnoses of Meningioma, Obesity, Dementia, Oral Dysphagia, Gastroesophageal Reflux Disease and Personality Change Due to Brain Tumor. Review of the physician's order dated 1/12/11 documented, "...FEEDING PRECAUTIONS: SMALL SIPS, SIT UPRIGHT, ASSISTANCE WITH MEALS AS NEEDED, ALTERNATE BITES WITH SIPS... BODY / BED ALARM WHILE IN BED / WHEELCHAIR..."</p> <p>Observations in the dining room on 1/18/11 at 11:55 AM, Certified Nursing Assistant (CNA) #1 gave 6 bites of food to Resident #7 before</p>	F 282 F 309	<p>4. The DON/charge nurse will monitor to ensure Physician orders are being followed r/t feeding precaution and fall interventions weekly for 4 weeks, monthly x3 months then quarterly for the next 12 months. Findings will be reported to the QA committee monthly x1 then quarterly for the next 12 months. The QA committee consist of ADM, DON MR, FS, Pharmacy, SS, ACT, environmental services, MDS coordinator and others.</p>	

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F 309	Continued From page 8 offering any liquid. Observations in the dining room on 1/18/11 at 11:41 AM and on 1/19/11 at 7:40 AM, revealed Resident #7 sitting in a wheelchair with no chair alarm on the wheelchair as ordered.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on policy review, observations and interviews, it was determined the facility failed to ensure the facility's environment remained free of potential accident hazards by not ensuring the door to 1 of 3 (100 hall) janitor's closets was kept locked and the floor was kept clean. The laundry staff failed to clean the lint screen in the two dryers in the laundry room. The findings included: 1. Review of the "Environmental Services Storage Areas" policy documented, "...1. All Storage areas shall be kept free from accumulation of trash, rubbish, paper ...at all	F 323	F323 : 1. The door to the janitor's closet was closed and locked and the floor cleaned on 1-20-11 by Housekeeping supervisor. The lint filters on the 2 dryers were cleaned on 1-2011 by Housekeeping supervisor. 2. The Administrator and Housekeeping Director made rounds observing doors to other similar areas for locking and to ensure the floors were cleaned and the lint filters to the remaining dryers were checked and cleaned as needed on 1-20-11.	2/28/11

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F 309	<p>Continued From page 8 offering any liquid.</p> <p>Observations in the dining room on 1/18/11 at 11:41 AM and on 1/19/11 at 7:40 AM, revealed Resident #7 sitting in a wheelchair with no chair alarm on the wheelchair as ordered.</p> <p>Observations in Residents #7's room on 1/19/11 at 11:10 AM, revealed Resident #7 lying in bed with no alarm on the bed as ordered.</p>	F 309	<p>3. The laundry and housekeeping staff were in serviced on cleaning lint filters , keeping the doors to the janitor's closet locked and the floors cleaned on 1-20-11 by Housekeeping supervisor.</p> <p>Door locks to areas that are to remain locked were replaced with self locking mechanisms on 2-1-11.</p> <p>4. The Laundry manager will check lint filters 5 days a week for 1 week then weekly for 3 weeks, then monthly for 2 months.</p> <p>The Administrator or designee will check doors that need to be locked weekly for 1 month.</p> <p>The results of these observations will be reported to the QA committee monthly for 3 months. The QA committee consist of ADM, DON, MR,</p> <p>FS, Enviromental services, SS, ACT, Pharmacy, and others.</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 policy review, observations and interviews, it was determined the facility failed to ensure the facility's environment remained free of potential accident hazards by not ensuring the door to 1 of 3 (100 hall) janitor's closets was kept locked and the floor was kept clean. The laundry staff failed to clean the lint screen in the two dryers in the laundry room.</p> <p>The findings included:</p> <p>1. Review of the "Environmental Services Storage Areas" policy documented, "...1. All Storage areas shall be kept free from accumulation of trash, rubbish, paper ...at all</p>	F 323		

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F 323	<p>Continued From page 9 times..."</p> <p>Observations in the 100 hall janitor's closet on 1/19/11 at 4:30 PM, revealed an unlocked door. There was a five (5) gallon container of Emerald Enhanced Floor Cleaner with four (4) gallons of solution in the container. The floor near the door and under a housekeeper's cart in the 100 hall janitor's closet was wet with a measurement of a two by two foot area of clear fluid.</p> <p>During an interview and walk-through of the 100 hall janitor's closet on 1/19/11 at 5:12 PM, the Administrator stated, "...door should be locked... I don't know what that liquid is in [on] the floor..."</p> <p>During an interview and walk-through of the 100 hall janitor's closet on 1/20/11 at 8:20 AM, the Environmental Services / Laundry supervisor was asked what is the expectation concerning the janitor closet. The Environmental Services / Laundry supervisor stated, "...expect closet door to be locked and room to be clean..."</p> <p>During an interview in the Administrator's office on 1/20/11 at 9:45 AM, the Administrator was asked if they had a chemical storage policy. The Administrator stated, "...I have looked through the housekeeping policies, our ES [Environmental services] is contract and I could not find anything about chemical storage..."</p> <p>2. Review of the facility's "Laundry" policy documented, "...lint traps and screens must be cleaned in each dryer on a regular basis..."</p> <p>Observations in the laundry department on 1/19/11 at 4:25 PM, revealed the lint screens in the two dryers were covered with lint.</p>	F 323		

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F 323	Continued From page 10 During an interview and walk-through of the laundry department on 1/19/11 at 5:08 PM, the Administrator was requested to look at the lint screen in both dryers. The Administrator stated, "...laundry leaves around 2:00 to 3:00 PM, they are gone for the day... both dryer screens have lint... they are supposed to clean and log it... I don't see a log..." During an interview and walk-through of the laundry department on 1/19/11 at 5:20 PM, the ES/laundry supervisor was asked what is the expectation of cleaning the lint screen. The ES/laundry supervisor stated, "...yes, I see the lint... there should be a log book to log cleaning..." The ES/laundry supervisor phoned the laundry staff per cell phone. The ES/laundry supervisor stated, "...they [laundry staff] sweep it [lint screen] out after every load and there is no log... staff is gone for the day, should have swept it [lint screen] out before going home... sweeping every time they take the load out..."	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on policy review, review of the "MED-PASS COMMON INSULINS: PHARMACOKINETICS, COMPATIBILITY, AND PROPERTIES" provided by the American Society of Consultant Pharmacists, medical record review, observations and interviews, it was determined the facility failed to ensure that the	F 333	F333 1. Nurse #2 and #3 was re-educated by the DON on 2-1-11 regarding administration of Insulin within the proper time frame of meals and following specific Metformin order r/t meals as MD ordered. RR #1 is now having Insulin administered within the proper time frame before meals. RR# 2 Metformin administration time has been changed per MD orders.	2/20/11

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F 333	<p>Continued From page 11</p> <p>residents were free of significant medication errors when 2 of 4 nurses (Nurses #2 and 3) administering medications failed to administer insulin within the proper time frame before meals and failed to administer Metformin with a meal as ordered by the physician.</p> <p>The findings included:</p> <p>1. Review of the facility's "SPECIFIC PROCEDURES FOR ALL MEDICATIONS" policy documented, "...Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered based on mealtimes..."</p> <p>2. Review of the "MED-PASS COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties" provided by the American Society of Consultant Pharmacists for typical dosing administration of insulin related to meals documented, "...NOVOLIN R... ONSET (in hours, Unless Noted)...0.5- [to] 1 hours... 30 minutes before meals".</p> <p>Medical record review for Random Resident (RR) #1 documented an admission date of 11/19/10 with diagnoses of Rehabilitation after Cerebrovascular Accident. Review of the physician's orders dated 1/4/11 documented, "...ACCUCHECK FSBS [finger stick blood sugar] AC [before meals] / [and] HS [hour of sleep] WITH NOVOLIN R [regular] SSI [sliding scale insulin] AS FOLLOWS: 0- [to] 149= [amount of insulin to be administered] 0U [units], 150-200=2U, 201-250=4U, 251-300=6U, 301-350=8U, 351-400=10U, 401-450=12U, 451 OR > [greater than] 14U, NOTIFY MD IF BS < [less than] 50 OR > 400..."</p>	F 333	<p>2. Residents receiving Insulin have the potential to be affected. DON reviewed resident's receiving Insulin and found meals being served timely according to the type of Insulin on 2-2-11.</p> <p>3. Meal tray/tray services revised to 2-1-11 to ensure timely meal service to residents receiving Insulin.</p> <p>4. The DON/charge nurse will observe Insulin administration in relation with meals service. This will be done daily x 2 weeks, weekly x 2 weeks and quarterly for the next 12 months. The results of the observation of Insulin and meal service time will be reported to the QA committee monthly x3 months then quarterly for the next 12 months. The QA committee consist of:</p> <p>ADM, DON, FS, SS, MR, MDS, Pharmacy and others.</p>	

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F 333	Continued From page 12 Observations in RR #1's room on 1/18/11 at 11:13 AM, revealed Nurse #2 administered Novolin R 2 units to RR #1. RR #1 was not served his noon meal until 12:12 PM and did not receive assistance eating until 12:24 PM which was 71 minutes after the resident received the insulin. During an interview with the Director of Nursing's (DON) office on 1/19/11 at 5:17 PM, the DON was asked what is the time frame for administering SSI before a meal. The DON stated, "...30 minutes before meals..." 3. Medical record review for RR #2 documented an admission date of 8/27/10 with diagnoses of Diabetes Mellitus, Blindness Both Eyes, Anxiety and Hypertension. Review of the physician's orders dated 8/27/10 documented, "...METFORMIN 500 MG [milligrams] TABLET 1 PO [by mouth] BID [two times a day] WITH MEALS..." Observations in RR #2's room on 1/19/11 at 7:34 AM, Nurse #3 administered Metformin to RR #2. RR #2 was not served her meal with the medication. During an interview at the nurse's station on 1/19/11 at 12:25 PM, Nurse #3 was asked if there was a meal in RR #2's room when RR #2 received her medication. Nurse #3 stated "No."	F 333		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is	F 364		

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F 364	<p>Continued From page 13</p> <p>palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on confidential interviews, the group interview and observations of a test tray, it was determined the facility failed to prepare food that conserves the flavor, appearance and palatability for 4 of 9 alert and oriented residents (Residents #3 and #14 and Random Residents (RR) #3 and #4) attending the group interview and for 4 residents who wish to remain confidential.</p> <p>The findings included:</p> <ol style="list-style-type: none"> During the initial tour on 1/18/10 beginning at 8:45 AM, confidential resident interviews revealed the following: <ol style="list-style-type: none"> A confidential resident stated, "If you eat in the dining room it is warm, if you eat in your room it is cooler." A confidential resident stated, "... Too much spice, may look like mashed potatoes but they taste odd..." A confidential resident stated, "... Food cold most of the time..." A confidential resident stated, "... Food not good, but I ate it, it is always cold..." During the group meeting in them medical records room on 1/18/11 at 3:00 PM, residents voiced the following complaints in regard to foods: <ol style="list-style-type: none"> Resident #3 stated, "Not cooked right." Random Resident (RR) #3 stated, "...same thing everyday for breakfast... grits not done... food on the hall is cold." RR #4 stated, "... Food is horrible too spicy and 	F 364	<p>F364</p> <ol style="list-style-type: none"> Plate warmers and covers were ordered on 2/2/11 and will be implemented on arrival. The RD consultant visited the facility on 2-4-11 to review menus and preparation A resident council meeting was held on 2-4-11 to identify other residents with the potential to be affected. The Dietary manager and dietary staff were in serviced by the RD consultant on 2-4-11 regarding food preparation. Plate warmers and covers were ordered and will be implemented on arrival. 	2/20/11

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F 364	Continued From page 14 too Italian... alternate worse than regular... only get peanut butter and crackers for bedtime snack..." d. Resident #13 stated, "...food on the hall is cold." 3. Observations of the test tray in the conference room on 1/19/11 at 12:20 PM, revealed the following: a. Mechanical soft pork and gravy was 110 degree Fahrenheit (F) and not palatable. b. Corn 122 F degrees and not palatable. c. Potatoes and gravy 118 F degrees very salty and not palatable. During an interview in the conference room on 1/19/11 at 12:20 PM, the Surveyor offered the Certified Dietary Manager (CDM) to sample the meal. The CDM gave no response nor tasted the food.	F 364	4. The Administrator and/or designees will sample a test tray from each meal weekly for 4 weeks and then monthly for 3 months. The Dietary manager/designee will monitor food temperatures of trays for each meal served on the hallway 5 times a week for 1 week and then weekly for 4 weeks and then monthly for 3 months. The facility representative to Resident Council will ask for concerns about food during each meeting for the next 6 months. The results of this monitoring will be reported to the QA committee monthly for 6 months.	
F 371 SS-E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on policy review, observations and an interview, it was determined the facility failed to ensure food was prepared or stored under	F 371		

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NAME OF PROVIDER OR SUPPLIER BAILEY PARK CLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MITCHELL STREET HUMBOLDT, TN 38343	
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F 364	Continued From page 14 too Italian... alternate worse than regular... only get peanut butter and crackers for bedtime snack... d. Resident #13 stated, "...food on the hall is cold." 3. Observations of the test tray in the conference room on 1/19/11 at 12:20 PM, revealed the following: a. Mechanical soft pork and gravy was 110 degree Fahrenheit (F) and not palatable. b. Corn 122 F degrees and not palatable. c. Potatoes and gravy 118 F degrees very salty and not palatable. During an interview in the conference room on 1/19/11 at 12:20 PM, the Surveyor offered the Certified Dietary Manager (CDM) to sample the meal. The CDM gave no response nor tasted the food.	F 364		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on policy review, observations and an interview, it was determined the facility failed to ensure food was prepared or stored under	F 371	F371 1. Equipment was cleaned on 2-4-11. Grease was removed from the grease trap on 1-18-11. Foods not labeled and/or dated were discarded on 1-18-11. Pots and pans were moved on 1-19-11. A beard cover was applied on 1-18-11.	2/20/11

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F 371	<p>Continued From page 15</p> <p>sanitary conditions as evidenced by equipment not being clean, grease in food traps, foods not labeled and dated, pots and pans stored over a potential contamination area and staff failed to wear beard covers on 2 of 3 (1/18/11 and 1/19/11) days of the survey.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the facility's "Food Storage" policy documented, "...8. All foods stored in refrigerators and freezers that have been opened, will be covered and labeled with the date and name of food if appropriate, and will be discarded within the appropriate time frame..." <p>During the initial tour of the kitchen on 1/18/11 beginning at 8:45 AM revealed the following:</p> <ol style="list-style-type: none"> Mixer had a green dried substance around top edges. Large amount of black, dried, hard matter in the grease trap. Freezer #1 contained chicken strips and patties, veal patties, catfish filet and box of biscuits not labeled or dated. White freezer contained later tots, okra and pound cake not labeled or dated. Pots, pans and utensils hanging on a rack over the three compartment sink. The Certified Dietary Manager (CDM) and a dietary staff member were not wearing covers over their beards. <ol style="list-style-type: none"> Observations in the kitchen on 1/19/11 at 11:55 AM, the CDM and another dietary staff member were not wearing covers over their beards. <p>During an interview in the conference room on</p>	F 371	<ol style="list-style-type: none"> A review of daily resident reports was conducted by the DON on 1-19-11 for evidence of any food borne illness among the residents. No evidence was noted. A thorough inspection on the kitchen was conducted by the RD consultant on 2-4-11. The Dietary Manager and staff were in serviced regarding storing and preparing food under sanitary conditions on 1-18-11. The Administrator/designee will observe sanitary conditions in the kitchen 5 times a week for 2 weeks, then weekly for 2 weeks, and then monthly for 2 months. The RD consultant will observe kitchen sanitation monthly ongoing. The results of the observations will be reported to the QA committee monthly ongoing. Committee members include: ADM, DON, FS, Act, SS, MDS, MR, environmental services and others. 	
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F 371	Continued From page 16 1/20/11 at 9:55 AM, the surveyor told the CDM of the findings in the kitchen. The CDM confirmed that he was aware that facial hair had to be covered and that the pot, pans and utensils should not be over the three compartment sink.	F 371		
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>	F 431	<p>431</p> <p>The insulin was discarded by DON on . RR#1 was assessed by the DON on 1-18-11 and had no adverse affects. The multidose container of colace was discarded by the DON on 1-19-11. Resident #1 as assessed by the DON on 1-19-11 and had no adverse affects. Nurse #4 was re-educated by the DON on 2-1-11 regarding leaving medication out of view. 4 tablets of Lorazepam and 2 bottles of saline in the med room were discarded by the DON on 1-20-11.</p> <p>2. The remaining insulin, multidose containers, and other medications in the med room and med carts were reviewed by the DON and designated nurses for open dates, expiration dates. Items were discarded as needed.</p>	2/20/11

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(X4) ID PREFIX TAG F 431	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 431	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observations and interviews, it was determined the facility failed to ensure medications were dated when opened and expired medications were discarded in 3 of 4 (100 hall medication cart, 200 hall medication cart and medication room) medication storage areas and 1 of 4 medication nurses (Nurse #4) left a medications unattended and out of her view.</p> <p>The findings included:</p> <p>1. Review of the facilities "SPECIFIC PROCEDURES FOR ALL MEDICATIONS" policy documented, "...under the direct observation of the medication nurse... Check expiration date on package / container. When opening a multi-dose container, place the date on the container..."</p> <p>2. Observation on the 100 hall on 1/18/11 at 11:05 AM revealed, Nurse #4 obtained a vial of Novolin Regular (R) insulin from the 100 hall medication cart and administered insulin to Random Resident (RR) #1. The Novolin R insulin vial had an open date of 12/15/10. The insulin vial had been opened and in use for 34 days.</p> <p>During an interview outside of RR #1's room on 1/18/11 at 11:10 AM, Nurse #4 was asked what is the policy for disposal of multi-dose vials. Nurse #4 stated, "28 days."</p> <p>During an interview at the nurses' station on 1/19/11 at 4:05 PM, the Pharmacist stated, "Insulin is good 28 days after opened."</p>		<p>3. The licensed nursing staff were in serviced by the DON regarding expired medication, dating containers upon opening, shelf life of 28 days for insulin after opening and keeping medication within view.</p> <p>The DON/designee will check medications rooms and carts for open dates and expiration dates weekly for 4 weeks and then monthly for 2 months. The Pharmacy consultant will check the same and observe medication pass monthly for 6months.</p> <p>The results of these observations will be reported to the QA committee monthly for 6 months. Committee members include: ADM, DON, Pharmacy, MD, SS, ACT, MR, MDS and others.</p>	

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F 431	<p>Continued From page 18</p> <p>During an interview in the Director of Nursing's (DON) office on 1/19/11 at 5:30 PM, the DON was asked what was the policy for insulin that has been opened for more than 28 days. The DON stated "...throw it away" referring to the expired insulin.</p> <p>3. Observations on the 200 hall on 1/19/11 at 3:30 PM, Nurse #4 obtained a 100 milligrams (mg) of Colace from a multi-dose container and administered the Colace to Resident #1. The multi-dose container did not have an open date on it.</p> <p>During an interview outside of Resident #1's door on 1/19/11 at 3:30 PM, Nurse #4 was asked if she saw an open date on the multi-dose container of Colace. Nurse #4 stated, "No."</p> <p>During an interview in the conference room on 1/20/11 at 1:50 PM, the DON was asked if every multi-dose bottle that is open is expected to be dated with an open date. The DON stated, "Yes."</p> <p>4. Observations in Resident #1's room on 1/19/11 at 3:33 PM, Nurse #4 left Colace at Resident #1's bedside, unattended and out of her view while she went into the bathroom.</p> <p>5. Observations in the medication room on 1/20/11 at 10:58 AM, revealed four tablets of Lorazepam with an expiration date of 12/10 and two 100 cubic centimeter (cc) bottles of sterile saline with an expiration date of 9/10.</p> <p>During an interview in the medication room on 1/20/11 at 11:05 AM, the DON stated, "Each shift checks amounts but not the expiration date."</p>	F 431		
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F 431	Continued From page 19	F 431		
F 441	Pharmacist spot checks...	F 441		
SS-D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS. The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441 1. CNA #1 and #2 was re-educated on 2-1-11 by the DON regarding infection control practices related to using sanitary hand hygiene, touching food, straws with their bare hands. 2. The DON observed meal tray passing on 100, 200 and 300 halls on 1-31-11 to identify other potential resident's that may be affected. CNA's were noted to be using sanitary hand hygiene, not touching food or straws with their bare hands. 3. Nursing staff were inserviced 2-1-11 regarding the hand washing policy and resident meals service on the hall. One staff member will push cart and open the cart door, other staff members will wash their hands, take tray from cart into resident room and set up meal if necessary, if you touch resident or equipment wash hands and wash hands before leaving the resident's room.	2/20/11	

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F 441	<p>Continued From page 20</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observations and interview, it was determined 2 of 3 Certified Nurses Assistants (CNAs #1 and #2) failed to ensure infection control practices were used to prevent the potential spread of infection by not using sanitary hand hygiene, touching food and straws with their bare hands.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's "Nursing Procedure Manual HANDWASHING" policy documented, "...general instructions... 1. hands should be thoroughly washed before and after providing resident care..." Review of the facility's "Infection Control Manual HANDWASHING" policy documented, "...procedure... 2f. Before touching, preparing, or serving food..." 2. Observations in the 100 hall on 1/19/11 at 8:00 AM, CNA #1 removed a meal tray from the cart, delivered the tray to Room 108, set up the tray and returned to the meal cart. CNA #1 never washed her hands. CNA #1 proceeded to push the meal cart to the 300 hallway, reached in the meal cart, removed a meal tray and delivered the tray to Room 307. While in Room 307, CNA #1 touched the wheelchair foot rest, repositioned the resident, opened the juice carton, opened the milk carton, prepared the meal tray and touched the straw with her bare hand. CNA #1 left the room, returned to the meal cart and pulled out another tray. CNA #1 never washed her hands. 	F 441	<p>4. DON will monitor meal service at least 3x a week x 1 month, then once a month for 12 months. Findings of the resident's meal service on the hall will be reported to the QA committee monthly x 1 month then quarterly. QA committee members include: ADM, DON, MR, FS, Pharmacy, SS, ACT, Environmental services, MDS coordinator and others.</p>	

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F 441	Continued From page 21 Observations in room 204 on 1/19/11 at 8:15 AM, CNA #1 cranked the head of bed up, prepared the tray, touched the straw with her bare hand, cut up eggs with a spoon, touched the sausage patty with her bare hand and placed the patty on the bread. CNA #1 left the resident's room, returned to the meal cart, and removed another tray. CNA #1 never washed her hands. 2. Observations in the 200 hall on 1/19/11 at 8:12 AM, CNA #2 removed a meal tray from the cart, delivered the tray to Room 208 then returned to the meal cart. CNA #2 pulled another tray from the meal cart and delivered the tray to Room #204. CNA #2 never washed her hands. 3. During an interview in the conference room on 1/20/11 at 10:20 AM, the Director of Nursing (DON) was asked what is the expectation of hand hygiene when passing and preparing the meal tray. The DON stated, "...wash hands before go in [the room], wash hands if they touch the resident or equipment... they [staff] should wash their hands..."	F 441		
F 465 SS-E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on policy review, observations and interviews, it was determined the facility failed to ensure the environment was clean and sanitary	F 465	F465 1. Shower chairs were cleaned on 1-19-11. Wash cloths found in the shower stall were placed in the proper receptacle, and the brush was discarded on 1-19-11.	2/20/11

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F 465	<p>Continued From page 22</p> <p>as evidenced by soiled shower chairs, soiled wash cloths in the shower stall and an orange substance on a brush in the shower stall in 3 of 3 (100 hall, 200 hall and 300 hall spa rooms) spa rooms.</p> <p>The findings included:</p> <p>1. Review of the facility's "Cleaning Schedule 10pm-6am shift" policy documented, "...clean shower chairs nightly or as needed..."</p> <p>Observations in the 200 hall spa room on 1/19/11 at 4:22 PM, revealed a splattered pattern of brown/black substance under the shower seat, a bed side commode bucket with the lid cover and the bottom of the bucket had a dried, brown substance with foul smelling odor and a long handled white brush with large amount of orange substance in the bristles of the brush head.</p> <p>During an interview in the 200 hall spa room on 1/19/11 at 5:04 PM, the Administrator stated, "...we use the brush I think to clean the shower stall... I smell the odor when the lid was lifted, it should have been cleaned... it looks like poop under the seat..."</p> <p>2. Observations in the 100 hall spa room on 1/19/11 at 4:27 PM, revealed a soiled wash cloth hanging on the hand rail in the shower stall.</p> <p>During an interview in the 100 hall spa room on 1/19/11 at 5:10 PM, the Administrator stated, "...another dirty wash cloth..."</p> <p>3. Observations in the 300 hall spa room on 1/19/11 at 4:20 PM, revealed a soiled wash cloth hanging on the hand rail in the shower stall.</p>	F 465	<p>2. All 3 shower rooms were identified as affected.</p> <p>3. The nursing and housekeeping staff has been in serviced regarding a clean and sanitary environment to include cleaning shower chairs, placing soiled linen in proper receptacles, and cleaning and storing the cleaning items.</p> <p>4. The DON/designee will check the shower rooms and shower equipment for cleanliness 5 days a week for 2 weeks, then weekly for 2 weeks and then monthly for 2 months. The results of these observations will be reported to the QA committee monthly for 3 months. Committee members include: ADM, DON, SS, MR, MDS, ACT, Physician, Pharmacy consultant and others.</p>	
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F 465	Continued From page 23	F 465		
F 502 SS=D	<p>During an interview in 300 hall spa room on 1/19/11 at 5:00 PM, the Administrator stated, "...the washcloth should be put in the dirty linen..."</p> <p>During an interview in the conference room on 1/20/11 at 2:35 PM, the Administrator stated, "...don't have a policy what to clean with, can't find any other policies about equipment cleaning."</p> <p>483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to ensure laboratory (lab) services were obtained as ordered by the physician for 1 of 13 (Resident #2) sampled residents.</p> <p>The findings included:</p> <p>Medical records review for Resident #2 documented an admission date of 2/26/09 with diagnoses of Diabetes Mellitus, Cerebrovascular Accident with Right Hemiplegia, Hypertension, and Dementia. Review of the physician's recertification orders dated 10/13/10 documented, "...PT [Protime] / INR [International Normalized Ratio] Monthly..." The lab was due in October 2010. The facility was unable to provide documentation that a PT/INR was obtained in October 2010.</p>	F 502	<p>F 502</p> <ol style="list-style-type: none"> 1. Resident #2's lab was reviewed and MD notified. 2. Resident's lab orders were reviewed by the laboratory service representative and DON on 1/16/11. The laboratory service and DON will exchange order list to verify lab orders on a monthly basis. 3. Resident's reciving PT/INR levels will be reviewed weekly by DON x 1 mo. Then monthly for the next 12 months. 4. Findings of the laboratory audit will be reported to the QA committee quarterly for the next 12 months and as needed. The QA committee consist of : ADM, DON, MD, FS, Pharmacy, SS, ACT, MDS coordinator and others. 	2/20/11

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445339	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		FEB 04 2011 (X3) DATE SURVEY COMPLETED 01/20/2011
NAME OF PROVIDER OR SUPPLIER BAILEY PARK CLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MITCHELL STREET HUMBOLDT, TN 38343		
(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 502	Continued From page 24 During an interview at the nurses' station on 1/19/11 at 12:10 PM, the Director of Nursing (DON) stated, "...I reviewed the chart, I have not found the PT/INR for October [2010]... order monthly can not find October..."	F 502			