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

45th 8/02/14

PRINTED: 06/26/201
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445511		06/18/2014

NAME OF PROVIDER OR SUPPLIER: LIFE CARE CENTER OF OOLTEWAH

STREET ADDRESS, CITY, STATE, ZIP CODE: 5911 SNOW HILL ROAD, OOLTEWAH, TN 37363

(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 During the annual recertification survey and investigation of complaints #32865 and #33380 conducted on June 16-18, 2014, at Life Care Center of Ooltewah, no deficiencies were cited in relation to complaint #32865 under CFR PART 483.13, Requirements for Long Term Care.	F 000	This plan of correction is submitted and required under Federal and State regulations and statutes applicable to long term care providers. The plan of correction does not constitute an admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan of correction does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited is correctly applied.	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on review of the resident council minutes, review of the comment/concern log, and interview, the facility failed to resolve complaints related to call lights for three of six months of resident council minutes reviewed and three of seven months of comment/concern logs reviewed. The findings included: Review of the Resident Council Minutes dated November 2013, revealed, "...One concern voiced was CNAs (certified nursing assistants) come answer call lights timely but leave to get help (and) don't return for long time frames..." Review of the Comment/Concern Log dated December, 2013, revealed, "...Issue...Call Lights..."	F 166	F166 1. Resident #194 was interviewed and no concerns were raised about timeliness of call lights. Other residents were safely discharged home. 2. All residents with potential to be affected were interviewed.	07/25/201

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jaimme Preston | TITLE: Executive Director | (X6) DATE: 7/3/14

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.

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F 166	Continued From page 1 Review of the Comment/Concern Log dated January 2014, revealed, "...Issue...Timeliness of call lights..." Review of the Resident Council Minutes dated February 2014, revealed, "...Report of call light not being answered because staff cannot see it was checked..." Review of the Resident Council Minutes dated April 2014, revealed, "...concern by Patient A no one answering...call light in a timely manner..." Review of the Comment/Concern Log dated April 2014, revealed, "...Issue...Timeliness of call light response..." Interview on June 18, 2014, at 9:30 a.m., with resident #194 (attends resident council meetings) in the resident's room, confirmed "it takes a long time to answer the call lights." Continued interview confirmed it did not occur on any particular shift. Interview with the Administrator on June 18, 2014, at 9:50 a.m., in the conference room, confirmed the call lights being answered timely continued to be a problem.	F 166	3. The Staff Development Coordinator conducted an educational in-service to all staff regarding the importance of answering call lights timely. Facility administration will conduct random call light audits at least three times a week for four weeks, then at least weekly for three months to ensure continued compliance. Executive Director will follow up on grievances to ensure that they are properly followed up on. 4. The Executive Director will obtain call light audits and report findings to the Quality Assurance Committee for three months. The Executive Director will monitor this process monthly to ensure continued compliance.	
F 314 SS=D	c/o #33380 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that	F 314	F314 1. Resident #92 and #205 were safely discharged home. 2. All residents with potential to be affected were audited and all were in compliance.	07/25/2014

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F 314	Continued From page 2 they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, and interview, the facility failed to ensure a nutritional assessment was completed timely for one resident (#92) and failed to ensure an assessment of pressure ulcers was completed timely for one resident (#205) of four residents reviewed for pressure ulcers of thirty residents reviewed. The findings included: Resident #92 was admitted to the facility on January 17, 2014, with diagnoses including Muscle Weakness, Diabetes, and Hypertension and was discharged on March 21, 2014, to another Long Term Care facility. Medical record review of the Physician's Recapitulation Orders dated January 2014, revealed "...1/17/2014...Megace (appetite stimulant) 40 mg (milligrams)...15 ml (milliliters) po (by mouth) daily..." Medical record review of the Braden Scale for Predicting Pressure Sore Risk dated January 18, 2014, revealed the resident scored a 14 (13-14 moderate risk). Medical record review of the Pressure Ulcer Status Record dated January 18, 2014, revealed, "...stage 3...coccyx...1.4 x (by) 1.5 cm	F 314	3. The Staff Development Coordinator conducted an educational in-service to the nursing staff regarding assessing and treating wounds within 24 hours of admission. The Director Food and Nutrition Services educated the Registered Dietician regarding the Nutrition and Wound policy. The Director of Nursing or designee will conduct audits on treatment administration records 5 times a week for four weeks and then weekly for three months to ensure compliance. The Director of Food and Nutrition services will audit the Registered Dietician's nutritional assessments for new residents weekly for one month and then monthly for 3 months to ensure compliance. 4. The Director of Nursing will report audit findings monthly to the Quality Assurance Committee for three months. The Director Food and Nutrition Services will report audit findings to the Quality Assurance Committee for three months. The Executive Director will monitor this process monthly to ensure continued compliance.	

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F 314	Continued From page 3 (centimeter) depth 1 cm..." Medical record review of the Nutrition Data Collection Assessment completed by the Registered Dietitian and dated January 31, 2014, revealed, "...1/21/14 Albumin 3.2 mild (decrease)...Pre-Albumin 22.9 WNL (within normal limits)...Total Protein 6.6 WNL... (Problem): Skin Breakdown... (Signs/Symptoms)...Stage III-Area Improving per 1/27/14 weekly wound summary...Nutrition Intervention: Megace for appetite stimulant...plan to include evening snack, Fortified AM Cereal (and) Prostat AWC (Advanced Wound Care) 30ml (milliliters) BID (twice a day) for healing wounds...wt (weight) stability and replace mild low ALB (albumin)..." Medical record review of a Physician's Order dated January 31, 2014, revealed "...Fortified AM cereal...Prostat...30 ml BID..." Medical record review of the Nutritional Progress Notes dated February 26, 2014, revealed, "...spoke with MD (physician). (Resident) refusing Prostat AWC. Recommend to discontinue Prostat...(resident) continues to need (increased) protein for healing. Met (with) (resident) to discuss protein preferences Requests 2 whole milk all meals..." Review of the policy Nutrition and Wounds, revealed, "...The Nutrition Data Collection/Assessment is completed for all residents within 72 hours of admission. Section III of the Nutrition Data Collection/Assessment is completed by the Registered Dietitian on the following visit..."	F 314		

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F 314	Continued From page 4 Interview with the Regional Nurse on June 18, 2014, at 12:30 p.m., in the conference room, confirmed the RD facility visit after the resident's January 17, 2014, admission was on January 23, 2014. Interview with the Administrator on June 18, 2014, at 12:40 p.m., in the conference room, confirmed there was a delay in the RD completing the nutritional assessment. Resident #205 was admitted to the facility on February 17, 2014, and readmitted to the facility on February 25, 2014, with diagnoses including Muscle Weakness, Pressure Ulcer, Paraplegia, Chronic Kidney Disease, Diabetes, and Colostomy and was discharged to the hospital on March 3, 2014. Medical record review of the Physician's Recapitulation Orders dated February 2014, revealed, "...Wound Care to Eval (evaluate) and Tx (treat) wound to Left buttock...Right Ischial...Left heel..." Medical record review of the Initial Data Collection Tool/Nursing Service dated February 17, 2014, revealed, "...time of admission: 4:30 p.m...." Medical record review of the PT (Physical Therapy) Plan of Treatment dated February 18, 2014, revealed "...Wound Care...patient exhibits stage 3 to buttock x (times) 2 sites and stage 2 to right heel measuring: Left Ischium: stage 3 3 cm (centimeter) L (length) by 4.2 cm W (width) by 2.0 cm D (depth) with a total surface area of 12.6 cm. Undermining between 12 o'clock to 3 o'clock 4.5 cm Moderate serosangeous drainage with 100%	F 314		

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F 314	Continued From page 5 (percent) beefy red tissue. R (right) Ischium: stage 3 measuring 13.5 cm L 9.0 cm W by 3.4 cm D with a total surface of 121.5 cm Tunelling at 12 o'clock measuring 7.5 cm Moderate serosangeous drainage with 100% granulation. Left heel stage 2 measuring 4.0 cm by 3.5 cm by 0.2 cm with a total surface of 14 cm with 25% slough/necrotic tissue, minimal serosangeous drainage..." Medical record review of a Physician's Order dated February 19, 2014, revealed, "...R (right) great toe tip stage 1 cleanse (with) NS (normal saline)...pat dry apply skin prep daily and prn (as needed) until resolved...R bases 5th metatarsal unstagable wound cleanse (with) NS pat dry apply skin prep daily and prn until resolved...Lateral malleolus R foot unstagable wound cleanse (with) NS pat dry apply skin prep daily and prn until resolved...L (left) heel stage II cleanse (with) NS pat dry apply (named treatment) to wound bed cover (with) dry dressing change every other day (and) prn...L Ischium stage III cleanse (with) NS pat dry. Pack (with) (named treatment)...cover (with) dry dressing change daily and prn until resolved...R Ischium stage III cleanse (with) NS pat dry pack (with) (named treatment) cover (with) dry dressing change daily and prn until resolved..." Medical record review of the Pressure Ulcer Status Record dated February 19, 2014, revealed, "...Date First Observed: 2/19/14...R (right) great toe tip stage 1...1.5 x 2.0 cm depth 0...L (left) heel stage II...4.0 x 3.5 cm depth 0.2 cm...Lateral (malleous) R (right foot)...unstagable...1.5 x 1.1 cm depth 0...(right) base 5th metatarsal...unstagable...0.3 x 0.5 cm depth 0..."	F 314		

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F 314	Continued From page 6 Interview with the Medical Director on June 18, 2014, at 11:00 a.m., in the conference room, confirmed would have expected the wounds to be assessed and treated within twenty-four hours of admission (Admitted February 17, 2014). Continued interview confirmed no harm resulted to the resident in the one day delay of wound assessment and treatment.	F 314		
F 431 SS=D	c/o #33380 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,	F 431	**F431** 1. Medication storage room on 200 hall and medication cart #1 were audited. All medications that were out of compliance were immediately removed from stock. 2. All other medication storage rooms and medication carts were audited and were in compliance. 3. The Staff Development Coordinator conducted an educational in-service to the nurses regarding the Medication Storage policy. The Director of Nursing or designee will conduct audits weekly for four weeks for medication storage compliance, then monthly for three months to ensure continued compliance.	07/25/2014

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F 431	Continued From page 7 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility failed to follow medication storage policy on one of two halls. The findings included: Observation on the 200 hall, in the medication storage room, on June 17, 2014, at 3:30 p.m., revealed two dented cans of 8 ounce Nepro supplement; one 16 ounce bottle of Pepto Bismol with a manufacturer's expiration date of December 2013; and one 16 ounce bottle of Vi-Daily with a manufacturer's expiration date of May 2014. Interview with Licensed Practical Nurse (LPN) #6 on June 17, 2014, at 3:30 p.m., in the medication storage room, confirmed the medications were outdated. Observation of the 200 hall medication cart #1, on June 17, 2014, at 3:40 p.m., revealed an open bottle of 30 ounce Centrum liquid with a manufacturer's expiration date of March 2014. Interview with LPN #10 on June 17, 2014, at 3:40	F 431	4. The Director of Nursing will report findings to the Quality Assurance Committee for three months. The Executive Director will monitor this process monthly to ensure continued compliance.	

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F 431	Continued From page 8 p.m., at the 200 hall medication cart, confirmed the medication was expired. Review of the Medication Storage and Security in the Facility policy revealed, "...outdated, contaminated, or deteriorated medication...are immediately removed from stock, locked in a segregated area, and disposed of according to procedure for medication destruction..." Interview with Director of Nursing (DON) on June 18, 2014, 8:50 a.m., in the conference room, confirmed the medication storage policy had not been followed.	F 431		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure accurate and complete documentation on the Treatment Adminstration Record for two residents (#55 and #92) of thirty	F 514	F514 1. Resident #92 and #55 were safely discharged home. 2. All residents with potential to be affected were audited and all were in compliance. 3. The Staff Development Coordinator conducted an educational in-service to the nursing staff regarding accurate and complete documentation on the Treatment Administration Record. The Director of Nursing or designee will conduct audits on treatment administration records 5 times a week for four weeks and then weekly for three months to ensure compliance	07/25/2014

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F 514	Continued From page 9 residents reviewed. The findings included: Resident #55 was readmitted to the facility on January 14, 2014, with diagnoses including Pneumonia, Muscle Weakness, Encephalopathy, Hypertension, and Decubitus Ulcer, Upper Back and was discharged from the facility on February 21, 2014, to an assisted living facility. Medical record review of the Braden Scale for Predicting Pressure Sore Risk dated January 14, 2014, revealed a score of 18 (15-18 at risk). Medical record review of the Pressure Ulcer Status Record dated January 15, 2014, revealed, "...Stage 1...mid back...17 x (by) 1.3 cm (centimeters) depth 0 cm...Stage II...mid back (lower)...1.5 x 1.6 cm depth 0.2 cm..." Medical record review of the Weekly Skin Integrity Data Collection Form dated January 15, 2014, revealed the resident's bilateral heels were red. Medical record review of a Physician's Order dated January 15, 2014, revealed, "...skin tear rt (right) elbow-cleanse with NS (normal saline) pat dry apply xerform and dry dressing change M-W-F (Monday, Wednesday, Friday) and prn (as needed) until resolved...stage II mid back cleanse (with) NS apply (named treatment) and foam dressing M-W-F (and) prn until resolved...stage 1 mid back apply skin prep daily..." Medical record review of a Physician's Order dated January 31, 2014, revealed, "...left	F 514	4. The Director of Nursing will report audit findings monthly to the Quality Assurance Committee for three months. The Executive Director will monitor this process monthly to ensure continued compliance.	

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F 514	Continued From page 10 heel-cleanse with NS pat dry skin prep then (named treatment) and cover with dry dressing change every other day and prn until resolved...Rt heel-cleanse with NS pat dry skin prep area apply (named treatment) and cover with dry dressing change every other day until resolved..." Medical record review of the Treatment Administration Record dated January 2014, and Febuary 2014, revealed the wound care to the stage II mid back was provided on January 31, 2014 (Friday), February 4, 2014 (Tuesday), February 14, 2014 (Friday), and February 17, 2014 (Thursday) (Ordered Monday, Wednesday, and Friday). Medical record review of the Treatment Administration Record dated February 2014, revealed no documentation the wound care to the Stage 1 mid back was provided on February 1, 2, 3, 5, 7, 8, 9, 11, 16, 17, and 19, 2014 (ordered daily). Medical Record Review of the Treatment Administration Record dated January 2014, and February 2014, revealed the wound care was provided to the right and left heel on January 31, 2014 (Friday), February 4, 2014 (Tuesday), February 6, 2014 (Thursday), and Febuary 10, 2014 (Monday) (ordered every other day). Interview with the Director of Nursing (DON) on June 18, 2014, at 8:40 a.m., in the conference room, confirmed the documentation on the Treatment Administration Record was not complete and accurate. Resident #92 was admitted to the facility on January 17, 2014, with diagnoses including	F 514		

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F 514	Continued From page 11 Muscle Weakness, Diabetes, and Hypertension and was discharged on March 21, 2014, to another Long Term Care facility. Medical record review of the Braden Scale for Predicting Pressure Sore Risk dated January 18, 2014, revealed the resident scored a 14 (13-14 moderate risk). Medical record review of the Pressure Ulcer Status Record dated January 18, 2014, revealed "...stage 3...coccyx...1.4 x 1.5 cm depth 1 cm..." Medical record review of a Physician's Order dated January 18, 2014, revealed, "...stage 3 coccyx: cleanse with NS Apply skin prep to peri wound. Apply (named treatment) to open area. Secure with (named dressing). Change every Tuesday and Friday and prn until resolved..." Medical record review of the Treatment Administration Record dated January 2014, and February 2014, revealed the wound care to the stage III coccyx was provided on January 31, 2014 (Friday) and February 5, 2014 (Wednesday) (ordered every Tuesday and Friday). Interview with the DON on June 18, 2014, at 8:40 a.m., in the conference room, confirmed the documentation was incomplete for the wound care on the February Treatment Administration Record. c/o #33380	F 514		