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

PRINTED: 11/27/2013
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
PoC #2	445114		C 11/19/2013

NAME OF PROVIDER OR SUPPLIER: BRAKEBILL NURSING HOME INC.

STREET ADDRESS, CITY, STATE, ZIP CODE: 5837 LYONS VIEW PIKE, KNOXVILLE, TN 37919

(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 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, review of facility investigation, interview, review of an Employee Timecard Report, and observation, the facility failed to implement the abuse policy for nine residents (#1, #2, #3, #9, #10, #11, #12, #13, #14) of twelve residents reviewed. The findings included: Review of an undated facility policy titled Resident Abuse Prevention/Reporting Investigation revealed, "...To provide guidelines to support and protect the rights of its residents to be free from all forms of abuse...It is the facility's responsiblity to not only prevent abuse, but also those practices and omissions, neglect, and misappropriation of property...each incident will be investigated to determine the cause...All facility employees who observe any abuse activity will immediately intervene to stop this activity and protect the resident. The abuse will immediately be reported to the Director of Nursing, Social Service, Administrator, or Nursing Supervisor...The supervisor is responsible for assuring the safety of the resident and reporting immediately to the Administrator or Director of Nursing or designee. (Facility) will immediately	F 226	**F 226** **It is the practice of Brakebill Nursing and Rehabilitation Center to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of property.** **Corrective Action:** **Resident # 1: No opportunities to retro correct a statement from agency CNA. Statement was not obtained during investigation and allegation was not substantiated.** **Resident # 2: No opportunity to retro correct. Allegation was not substantiated. Additional witness statements and documentation regarding allegation not possible to obtain due to time that has expired on this incident.** **Resident #3: No opportunity to retro correct. LPN # 2 was interviewed regarding the alleged incident, but a signed statement was not obtained. As allegation was not substantiated, a statement from this nurse is no longer indicated.** **Diversion:** **August 31, 2013 Report: No opportunity to retro obtain or correct additional witness statements, notifications, or**	1-2-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

12-6-13

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 226	Continued From page 1 begin a thorough investigation of all alleged violations, prevent further abuse while the investigation is in progress...Any alleged victim will be examined immediately (if injury was suspected)...Any employee(s) involved in an alleged abuse will be removed from direct patient care of the specific resident and will be immediately placed on administrative leave...All associate(s) will report these concerns to their immediate supervisor...immediately. The Administrator and Director of Nursing will record these reports on an Unusual Incidents Occurrence form and immediately begin investigational process...The involved resident and all involved parties will be interviewed immediately..." Resident #1 was re-admitted to the facility on March 5, 2013, with diagnoses including Dementia with Behavioral Disturbance. Medical record review of a History and Physical dated March 6, 2013, revealed, "...Severe dementia with psychosis and behavior disturbance..." Medical record review of a nurse's note dated September 13, 2013, revealed, "refused VS (vital signs). very comb (combative) and noncompliant with instructions from staff. Refuses meds (medications) and was verbally abusive to CNAs (Certified Nursing Assistants). (Resident) was very upset abt (about) having a roommate. Shouted this is my room. I want everyone to leave. CNA was putting (resident's) roommate to bed when (resident) yelled out. (Resident) refused care and stated, 'I want them all fired.' Family notified. Supervisor notified. Several attempts at redirection was made with no	F 226	reconciliations. The nursing staff will be educated by 12/13/2013 on making sure medications are being delivered and are signed upon verifying each medication to be accurate based on the pharmacy delivery sheet. Pharmacy has been notified that the person responsible for delivering medications is required to sign the delivery sheet at the time of exchange. All nursing staff will be in-serviced by 12/13/2013 regarding accepting keys and counting narcotics to verify and sign that they are the on-going nurse and upon shift change they are to sign the off-going nurse sheet to verify that their count is accurate. Each medication cart contains the narcotic verification sheet that is located in front of every narcotic book. Per facility protocol it is required that two licensed personnel (DON, ADON, pharmacy nurse/liaison) are to be the only authorized individual that can collect narcotics that are required to be destructed. At no time can one of the personnel collect individually, two are required at all times to review and place in safe that is newly located in the Beige Wing (200) Wing medication room. Prior to placing and controlled substance in the safe, all narcotics are to be documented and counted on a method of destruction record sheet provided by the pharmacy. Upon destruction, that is done monthly, the	

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F 226	Continued From page 2 success." Review of an investigation report dated September 13, 2013, revealed, "...Resident was upset about roommates and staff being in (resident's room). (Resident) became combative and verbal (verbally) abusive after (resident) ordered everyone out of the room. (Resident) c/o (complained of) staff 'manhandling (resident)' to nurse. No evidence noted...skin assessment done. No bruising no swelling no discoloration noted...Refer to Social Services for further investigation...Person Completing Form (LPN #3)..." Medical record review of a Minimum Data Set (MDS) dated September 18, 2013, revealed the resident was severely impaired with decision-making skills and was verbally and physically abusive one to three days of the seven day assessment period (included September 13, 2013). Review of a facility investigation witness statement of CNA #1 dated September 13, 2013, revealed, "Agent lady was taking (resident's roommate) to bed an (and) I was helping her and (Resident #1) was in the bed laying down. And (resident) got mad because we were making noise and putting (roommate) to bed...got upset and start (started) crawling out of bed and trying to stand up. I advise (advised) (resident)...was going to fall, so I help (helped) (resident) on the chair, then (resident) start (started) saying (resident) was going to get the agent girl fire (fired), for grabbing on (resident)...I did not need to touch (resident) because I stood there and allow it. Then once got on the hallway (resident) start (started) making statements...been abuse	F 226	method of destruction sheet then again is reviewed by the pharmacist prior to discarding medications. The safe that the narcotics are kept in is provided by the pharmacy. The Director of Nursing is the only licensed personnel in the facility that has a key to the safe. The other individual who contains the other key is the pharmacist. Not one individual is able to unlock the safe without the other. Both keys to open the safe are required to be present in order for the safe to open. Resident #9: No action indicated or required. Resident #10: No action indicated or required. Resident # 11: No action indicated or required. Resident # 12: No action indicated or required. Resident discharged home. Resident # 13: : No action indicated or required. Resident admitted to hospital and did not return. Resident # 14: No action indicated or required. Resident on hospice and expired.	

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F 226	Continued From page 3 (abused) and other CNAs was asking by who so then (resident) pointed at me and the agent lady and just keep going on about hitting on (resident)." Review of a facility investigation witness statement of Licensed Practical Nurse (LPN) #3 dated September 13, 2013, revealed, "...I overheard (Resident #1) saying that (resident) was abused. When asked what happened (resident) said (resident) was not putting up with this (expletive deleted) and...I advised (resident) that I would call (resident's son). (Resident's son) was called but his wife answered I gave (resident) the phone and (resident) proceeded to tell her that (resident) was manhandled by 2 CNAs...said that they pulled (resident's) arm while getting (resident) up..." Medical record review of a Social Service note dated September 16, 2013, at 9:15 a.m., revealed, "Received voicemail message from (LPN #3) regarding resident's report that the CNAs were rough...SW met with resident today...says...caregivers are taking good care of (resident) except for a couple of times that they were rough...says 'they slung me by my arm' pointing to...right arm...says happened a couple of weeks ago...'one grabbed me by the arm.' (Resident) says...doesn't know their names but (resident will) recognize them..." Review of an Incident Investigation Questionnaire dated September 18, 2013, and signed by the Administrator, Director of Nursing (DON), Social Worker, and Assistant Director of Nursing (ADON), revealed, "...Who was involved in the alleged abuse (CNA #1)...(Resident) was laying in bed sleeping when...was awakened with the 2	F 226	**Identification of other residents having the potential to be affected:** **No other residents in the facility were identified as having the potential to be affected according to self-report records and resident samples.** **Measures to be put in place and systemic changes:** **The facility will review all reported allegations of mistreatment, neglect, and abuse of residents and misappropriation of property on a daily basis during the facilities morning administration meeting. A list of witnesses to allegations will be compiled and the facility will interview and obtain signed statements from each witness listed, indicating date and time of interview. Allegations will be entered into the UIRS reporting system within the time frame allowed. Folder of any allegations investigated will be available for review by the appropriate authorities consisting of incident reports, witness statements, supporting documentation and any other relative documents. The Director of Nursing, Administrator, or their assigned designee will be responsible for following investigative protocols. Director of Nursing will in-service all staff members regarding provisions of the**	

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F 226	Continued From page 4 CNAs putting...roommate to bed...stated that they twisted...arm when getting (resident) up...Summarize results of investigation: Statements from patient, CNA involved and witnesses obtained...no...abuse confirmed..." Review of the facility's investigation revealed no documentation regarding the identity of the second CNA responsible for putting the resident's roommate to bed on September 13, 2013, nor a statement from the second CNA. Telephone interview with the DON on November 15, 2013, at 10:20 a.m., revealed the agency CNA was CNA #6, the facility's investigation did not include a statement from CNA #6, and confirmed the facility failed to implement the abuse policy for thoroughly investigating an allegation of abuse. Resident #2 was admitted to the facility on December 22, 2010, with diagnoses including Organic Brain Syndrome and Neurotic Depression. Medical record review of an MDS dated August 26, 2013, revealed the resident was moderately impaired with decision-making skills and was dependent on staff for bed mobility, transfers, and toileting. Review of an investigation report dated September 7, 2013, revealed, "...Physical Assault/Altercation Alleged...Resident's daughter...came to this nurse et (and) stated (Resident) told her that a CNA or (2) CNAs were 'rough' with (resident) during provision of care...went with daughter to nsg (nursing) supervisor et (and) discussed resident's	F 226	resident abuse policy and reporting requirements as outlined in the policy. In –services will be completed by 1/2/2014, the date allowed under the terms of the 2567. Monitoring of corrective actions: Monitoring of corrections will be a continued, ongoing program utilizing Monitoring of corrections will be a continued, ongoing program utilizing the morning administration meeting and incident report reviews. In addition, the Director of Nursing and Administrator will also determine compliance during daily morning meeting and will also utilize direct observation and chart review samplings. Compliance will also be reviewed monthly as an ongoing monthly agenda item as a part of the monthly QA/QI process beginning 1/2/2014. Director of Nursing will in-service all staff members regarding provisions of the resident abuse policy and reporting requirements as outlined in the policy. In –services will be completed by 1/2/2014, the date allowed under the terms of the 2567.	

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F 226	Continued From page 5 complaints. Resident stated that 2...female CNAs were being unnecessarily rough with (resident) when they were turning and repositioning resident during personal care and the CNAs would not take (resident) to the bathroom but instead gave...a bedpan that had feces on it...prefers to be taken to the toilet with the lift and (resident) said the CNAs ignored (resident's) request... (identified CNA #4)..." Review of an undated Incident Investigation Questionnaire completed by the ADON revealed, "...Date & Time Reported: 9/7/13 11-7 (11:00 p.m.-7:00 a.m.) Person Reported To: (Director of Nursing)..." Medical record review of the nurses notes dated August 30, 2013, through September 9, 2013, revealed no documentation regarding the resident's allegations or assessment of the resident on September 7, 2013. Medical record review of a Weekly Skin Assessment dated September 10, 2013, revealed, "...some slight bruising on bilateral upper ext (extremities)..." Medical record review of a social service progress note dated September 11, 2013, revealed, "...ADON and this SW (social worker) came to interview resident this morning regarding report made by a nurse...(Resident's daughter)...told that there were 2 girls transferring (resident) and needed to raise (resident's) legs. Resident told these girls that...legs were hurting...CNA told the resident, who wants to go to the bathroom, to use bedpan instead..." Review of a witness statement from CNA #5	F 226		

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F 226	Continued From page 6 dated September 11, 2013, (four days after the resident's allegation) revealed, "...working...with (CNA #4) while in the room...with (resident) had to be cleaned up...needed a new brief and had to get ready for bed around 10:30 p.m...facts of what I saw I did not see or hear (resident) saying (resident's) legs hurt...was only concerned about...pillows under (resident's) legs so I had to make sure...pillows correct...(CNA #4), (nurse), and I...left out the room...did not say (resident) needed anything else before we walk (walked) out the room." Review of a statement signed by CNA #4 and dated September 13, 2013, (six days after the resident's allegation) revealed, "...I was told by CNA that (resident) was a 2 person assist. Me and (CNA #5) went and got the nurse...to go into room with us...(resident) had urinated on (self). We put (resident) on the sit to stand (mechanical lift) and cleaned (resident) up then put..to bed. (Resident) expressed anger when I criss crossed the sit to stand belts...also didn't like the way we placed the pillows under (resident's) legs." Review of the facility's investigation revealed no witness statement from the nurse referenced in CNA #4's statement. Review of CNA #4's time card dated September 10, 2013, revealed the CNA clocked in at 3:09 p.m. and out at 9:06 p.m. Observation and interviews with Resident #2 on October 9, 2013, at 3:28 p.m., and October 16, 2013, at 10:40 a.m., revealed the resident was extremely hard of hearing, able to insert a hearing aid, but unable to effectively communicate with or without a hearing aid.	F 226		

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F 226	Continued From page 7 Interview with Licensed Practical Nurse (LPN) #1 on October 16, 2013, at 10:45 a.m., at the nurse's station, revealed the resident was oriented with periodic confusion and LPN #1 was able to communicate with the resident. Interview with Resident #2 on October 16, 2013, at 10:50 a.m., in the resident's room, with the assistance of Licensed Practical Nurse (LPN) #1, revealed the resident had not been treated roughly or physically abused. Interview with the Social Worker on October 16, 2013, at 1:45 p.m., in the classroom, revealed the Social Worker was unaware of the resident's allegation until September 11, 2013. Interview with the DON on October 16, 2013, at 11:30 a.m., in the classroom, revealed the nurse who completed the incident report had not reported the allegation immediately and the DON did not become aware of the allegation until September 10, 2013. Continued interview revealed the DON called the facility as soon as became aware of the allegation on September 10, 2013, at approximately 9:00 p.m., and advised the supervisor to send CNA #4 home pending investigation. Continued interview revealed the resident was not assessed for injury until three days after the allegation and CNA #4 was not interviewed until September 13, 2013, six days after the resident's allegation. Continued interview confirmed the facility had not implemented the facility's abuse policy for notification of an allegation of abuse, suspension of employee during investigation of abuse, or thoroughly investigating an allegation of abuse.	F 226		

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F 226	Continued From page 8 Resident #3 was readmitted to the facility on June 17, 2013, with diagnoses including Parkinson's Disease, Pancreatic Mass, and Melanoma Resection. Medical record review of an MDS dated September 23, 2013, revealed the resident was moderately impaired with decision-making skills and rejected care one to three days of the assessment period. Medical record review of a nurse's note dated September 25, 2013, at 8:45 a.m., revealed, "called to shower room by assigned staff R/T (related to) skin tear on R (right) forearm. Unit mgr (manager) assessed and tx init (treatment initiated)." Review of an investigation report dated September 25, 2013, revealed, "...Date of incident 9/25/13...8:45 a.m...Type of incident...Skin Tear...Type of Care Steri-strip...Call to...shower by assigned staff R/T (related to) observed skin tear voiced to unit manager. Assessment provided/tx (treatment) initiated..." Review of an Incident Investigation Questionnaire revealed, "...Date & Time Reported: 9/25/13 (Time was not documented.) Person Reported To: (LPN #2)...Who was involved in the alleged abuse/(CNA #3)...Further describe the alleged physical abuse and the surrounding circumstances: Patient sustained skin tear to right wrist while being transferred from bed to sit to stand...Summarize results of investigation: small skin tear to right wrist." Review of CNA #1's statement dated September	F 226		

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F 226	Continued From page 9 25, 2013, revealed, "...I ask (CNA #3) for help putting (resident) in the shower chair. When enter (entered) the room (resident) started saying (resident's) daughter said (resident) didn't have to get up and I said well she told us that she would like to see you get up and take showers. (Resident) keep saying no she didn't say that, and just keep going on. (LPN #2) then came to talk to (resident) an advice (advised) (resident) of the same thing. Then we proceed to get (resident) up and (resident) became combative and holding on the bed rail and also to (CNA #3) so when (CNA #3) try to pull away from (resident), (resident) received...skin tear and started yelling lawsuit and etc. So I told (CNA #3) to leave I take it from here, because (resident) was upset and after I got (resident) to calm down (resident) had a visitor...(resident) proceed to talk about things that happen to (resident)...that people are been (being) mean to (resident), then started crying an (and) getting upset. And I just try to talk to (resident)...so I left..." Medical record review of a social service progress note dated September 26, 2013, revealed, "...received report of alleged abuse from the DON (Director of Nursing) today. SW (Social Worker) went to interview resident in (resident's) room...Resident said a CNA...(CNA #3) came to take (resident) to the shower...was told by (CNA #3) 'You will go anyway.' Resident then grabbed on to...left siderail and (stated) 'I held on for as long as I could. She pulled me apart.' Resident then showed...bruises on...left arm and then right with clear band aid..." Review of an undated statement completed by CNA #3 revealed, "I was helping (CNA #1)...being very agitated about not wanting a shower that	F 226		

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F 226	Continued From page 10 day. I went on to tell (resident) that (resident's) family wanted...hair done that day and...had a beauty shop appt. (appointment) that morning. While tranferring (resident) had one arm on the siderail and the other was holding onto my left arm. I informed (resident) that I would need for (resident) to let go of the siderail and my arm. When I pulled back the resident lost grip of my arm and caused a skin tear to (resident's) RFA (right forearm). Nurse was notified..." Review of the facility's investigation revealed no statement from LPN #2. Review of an Incident Follow-up and Recommendation Form signed by the DON on September 26, 2013, revealed, "...have reviewed all investigative data and have made the following determination: No abuse, neglect, misappropriation...Spoke with patient and nurses, CNAs that were present during incident...Skin assessments done prior to incident reflects pt (patient) to have bruising to bilateral upper extremities..." Interview with CNA #3 on October 16, 2013, at 12:32 p.m., in the classroom, revealed, "...(Resident's) CNA was having trouble with (resident) taking a shower. I talked (resident) into taking a shower and I left the room. I held the chair while they were transferring (resident). (Resident) wasn't refusing to take a shower...I asked (resident) if (resident) wanted up. A hospice staff and...CNA transferred...did not do anything abusive to (resident)." Interview with the DON on October 16, 2013, at 3:23 p.m., in the classroom, revealed the facility had not thoroughly investigated the resident's	F 226		

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

PRINTED: 11/27/2013
FORM APPROVED
OMB NO. 0938-0391

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F 226	Continued From page 11 allegation and confirmed the facility failed to implement the abuse policy. Review of a facility investigation report for an incident occurring on August 31, 2013, revealed, "Person involved (former DON)...Date of incident 8/31/13...Type of incident (blank)...Describe exactly what you observed or heard: On 8/31/13 an inspection for med (medication) destruction were found to be missing. Approximately 163 pills were found to have been punched out...also found to be not properly logged in. An investigation was initiated by the ADON..." Continued review revealed the report was completed by the ADON. Review of a facility investigation report dated September 5, 2013, revealed, "Medication Diversion. On 8/31/2013, an inspection and check on scheduled narc's (narcotics) for medication destruction were found to be missing. Medications were secured under double lock and in a safe that was kept in the Director of Nursing's Office. Approximately 163 pills were found to have been punched out on several of the medication cards...An investigation was initiated by the ADON, Pharmacy Liaison Nurse and a facility RN (Registered Nurse). Investigation is continuing..." Continued review revealed no additional investigation documentation. Interview with the Pharmacy Liaison Nurse on October 8, 2013, at 1:30 p.m., in the classroom, revealed the nurse became aware of the incident on September 3, 2013. She stated, "...was told that they went into DON's office and found 4-5 empty cards and with sheets that showed there should have been medication with them...(ADON) and I checked the rest of the meds that had been	F 226		

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

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F 226	Continued From page 12 in the safe in the DON's office...With facility's policy would need to be investigated..." Interview with the ADON on October 15, 2013, at 9:40 a.m., in the classroom, revealed the ADON was made aware of the incident on September 3, 2013, and both the ADON and the former DON had keys to the closet in the DON's office prior to the incident on August 31, 2013. The ADON stated, "...None of the meds were for any resident in house (current resident). (The current DON) was here (in facility)...when narcotics were discovered missing..." Interview with the current DON on October 15, 2013, at 10:13 a.m., in the classroom, revealed she was present when the medications were discovered in the closet on August 31, 2013. Interview revealed medication was on shelves in the closet, and empty medication cards and Controlled Substance Records were in a box in the closet. Continued interview revealed she was the only Registered Nurse in the facility when the medication was discovered and no inventory of the medications or Controlled Substance Inventory Records was completed on August 31, 2013. Interview with business office staff #1 on October 15, 2013, at 11:25 a.m., in the classroom, revealed she was present on August 31, 2013, when the medications were discovered in the closet in the DON's office. She stated, "...There was medication packets...on the shelves, on top of the safe...some on the floor beside the safe, scattered everywhere...also looked in file cabinets...and found more medication cards..." Continued interview revealed she had not completed a witness statement.	F 226		

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

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F 226	Continued From page 13 Interview with a maintenance man on October 15, 2013, at 12:25 p.m., in the classroom, revealed he cut a padlock off the closet in the DON's office on August 31, 2013, and was present when the doors were opened. Continued interview revealed he had observed medications in the closet and he stated, "...No one had me write a witness statement..." Interview with the Pharmacy Liaison Nurse on October 15, 2013, at 3:07 p.m., in the classroom, revealed she learned of the missing medication on September 3, 2013. She stated, "...My count (missing medications) based on looking at bubble packet and controlled substance records is 246..." Continued interview revealed she reported the incident to pharmacy staff and the Pharmacy Consultant. Interview with the facility's owner on October 16, 2013, at 9:52 a.m., in the classroom, revealed he had the facility's maintenance man cut the padlock off the closet in the DON's office on August 31, 2013, due to suspicions of drug diversion. Continued interview revealed he saw cards with medications stacked in the closet and on a safe in the closet. He stated, "...I think there was a couple of cards in the DON's desk drawer but I didn't know what that was..." Interview with business office staff #1 on October 18, 2013, at 1:20 p.m., in the office adjacent to the billing office, revealed she had not notified her supervisor of the incident on August 31, 2013. Interview and review of Controlled Substance Inventory Records with the Pharmacy Liaison Nurse on October 21, 2013, at 8:45 a.m., in the	F 226		

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

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OMB NO. 0938-0391

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F 226	Continued From page 14 classroom, revealed the following regarding current residents: Resident #9 had 27 Percocet (schedule II narcotic) 10/325 mg. (milligrams) missing; Resident #10 had 14 Alprazolam (anti-anxiety) 0.5 mg. missing; and Resident #11 had 9 Morphine Sulfate (schedule II narcotic) 15 mg. missing. Continued interview and review of Controlled Substance Inventory Records revealed the following regarding discharged residents: Resident #12 had 54 Lortab (schedule II narcotic) 5/500 mg. missing; Resident #13 had 27 Oxycodone/APAP (schedule II narcotic) 10/325 mg. missing; and Resident #14 had 35 Norco 5/325 (schedule II narcotic) mg. missing. Continued interview revealed the facility could not account for 166 pills. Telephone interview with the former DON on November 18, 2013, at 11:45 a.m., revealed he discovered the lock cut off a door in his office on September 2, 2013, and the facility's owner informed him it had been reported to business office staff #1 drugs had been taken from the closet. He stated, "...I was not comfortable with that..." Continued interview revealed he and the ADON had access to the closet and he stated, "...I don't know who had access after...cut lock off...don't understand why...(owner would) do that when I was gone and unaccountable for drugs..." Continued interview revealed he left the facility on September 2, 2013, and notified the Administrator he would not return. Resident #9 was admitted to the facility on August 8, 2013, with diagnoses including Hemiplegia Non-dominant Side. Medical record review of an MDS dated August 21, 2013, revealed the resident's BIMS (Brief	F 226		

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

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F 226	Continued From page 15 Interview Mental Status) score was 15 (cognitively intact). Interview with the resident on October 17, 2013, at 8:40 a.m., in the resident's room, revealed the resident was administered pain medication as needed, pain was controlled with the medication, and the resident had no difficulty obtaining medication in a timely manner. Resident #10 was admitted to the facility on November 23, 2010, with diagnoses including Osteoarthrosis. Medical record review of an MDS dated July 31, 2013, revealed a BIMS score was 14 (cognitively intact). Interview with the resident on October 17, 2013, at 10:10 a.m., in the resident's room, revealed the resident was administered pain medication every day and unable to identify the name of the pain medication. Continued interview revealed the medication was effective. Resident #11 was admitted to the facility on July 3, 2013, with diagnoses including Generalized Pain. Medical record review of an MDS dated October 9, 2013, revealed the resident's BIMS score was 14. Interview with the resident on October 17, 2013, at 10:00 a.m., revealed the resident was administered pain medication daily, the medication was effective, and the resident had no difficulty obtaining the medication.	F 226		

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

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F 226	Continued From page 16 Resident #12 was admitted to the facility on July 3, 2013, with diagnoses including Unspecified Disorders of Back. Medical record review of an MDS dated July 16, 2013, revealed the resident's BIMS score was 15. Medical record review of a nurse's note dated July 22, 2013, revealed, "dc'd (discharged) home with grandson." Resident #13 was admitted to the facility on July 19, 2013, with diagnoses including Fibromyalgia and Raynaud's Disease. Medical record review of a Nurse Practitioner's note dated August 9, 2013, revealed, "...chronic pain syndrome on multiple meds with improved control..." Medical record review of a nurse's note dated August 23, 2013, revealed the resident was sent to a hospital with an increased temperature and did not return to the facility. Resident #14 was admitted to the facility on March 20, 2012, with diagnoses including Chronic Airway Obstruction. Medical record review of a significant change of status MDS dated June 5, 2013, revealed no responses regarding the resident's cognitive status, the resident was totally dependent on staff for all activities of daily living and was free of pain. Medical record review of the August 2013 nurses notes revealed the resident was on hospice and expired on August 6, 2013.	F 226		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 226	Continued From page 17 Interview with the Administrator on November 19, 2013, at 1:20 p.m., in the Administrator's office, confirmed he had interviewed staff about the incident, had no witness statements, and confirmed the facility had failed to implement the abuse policy for investigating missing medications.	F 226		1-2-14
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigation, observation, and interview, the facility failed to provide medically-related social services for one resident (#5) of five residents reviewed. The findings included: Resident #5 was admitted to the facility on June 1, 2009, with diagnoses including Multiple Sclerosis, Personality Disorder, and Depressive Disorder. Medical record review of a Minimum Data Set dated July 31, 2013, revealed the resident was moderately impaired with decision-making skills, tired or had little energy nearly every day, and was totally dependent on staff for all activities of daily living.	F 250	**F 250** **Brakebill Nursing and Rehabilitation Center provides medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.** **Corrective Action:** **Resident # 5: Resident received follow-up services by Licensed Nursing staff on each shift following indicated incident. Resident was seen by Nurse Practitioner (NP) on August 22, 2013 for evaluation. Note in chart by NP indicated "resident needs f/u (follow-up) by social services...." . The Interpretive Guidelines for 483.15 (g) (1) under Guidance to Surveyors states "it is not required that a qualified social worker necessarily provide all of these services. Rather it is the responsibility of the facility to identify the medically related social service needs of the resident and assure that the needs are met by the appropriate disciplines". Listed**	

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F 250	Continued From page 18 Medical record review of the current care plan effective until May 22, 2014, revealed, "...Potential for mood alterations secondary to history of depression and MS (Multiple Sclerosis)...*Psych (psychiatric) eval (evaluation) and treatment as needed*Reassure resident as needed...SS (social services)..." Medical record review of a nurse's note dated August 16, 2013, at 3:30 p.m., revealed, "Another resident was observed hitting (resident) in...face and chest repeatedly...No injury, bruises, swellings, or discolorations...Social Services notified..." Review of a facility's investigation report dated August 16, 2013, revealed, "...another resident was observed hitting (Resident #5) in the face and chest repeatedly...I immediately left SS (Social Services) a voice mail informing of the incident...(LPN #3)." Medical record review of a care plan entry dated August 16, 2013, revealed, "Risk for emotional distress R/T (related to) encounter with aggressive resident...res (resident) will feel safe...provide emotional support et tx (and treatment) as needed Psych referral...SS (Social Services)..." Medical record review of a Nurse Practitioner's note dated August 22, 2013, at 2:00 p.m., revealed, "Follow up visit post (after) alleged abuse from another resident...reluctant to talk about where (resident) was 'hit'...Resident needs f/u (follow-up) by social services..." Medical record review of a physician's order	F 250	under the provisions of this regulation: • Providing or arranging provision of needed counseling services. • Finding options that most meet the physical and emotional needs of each resident. For the provisions indicated, services were met through observation, monitoring, and assessment by qualified nursing staff members and the facilities nurse practitioner for the period of August 16 – 22, 2013. Social services involved on August 22, 2013 following an order for "Psychotherapy evaluation to evaluate for post-incident stress, anxiety, or depression" Social services referral was initiated and resident was scheduled and seen by Psychotherapy services on September 5, 2013. Resident reported to not exhibit negative signs or symptoms or deviations from baseline normal behavior as a result of incident during this period. Resident has received all necessary care and services related to this incident. Identification of other residents having the potential to be affected: Record and incident review by DON confirmed that only the resident identified was affected.	

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F 250	Continued From page 19 dated August 22, 2013, at 2:30 p.m., revealed, "Social Services to F/U regarding safety concerns Psychotherapy evaluation to evaluate for post-incident stress, anxiety, or depression. Thanks." Medical record review of a mental health provider's documentation dated September 5, 2013, revealed, "...Reason for referral...was struck several times...will be little impact of...attack...only link to outside world is (resident's) TV..." Observation and interview with the resident on October 9, 2013, at 11:07 a.m., revealed the resident was in bed and visting with parents. The resident stated, "...I was just laying down and (another resident) came in and started hitting me...was the first time...didn't hurt me..." Interview with the Social Worker (SW) on October 9, 2013, at 10:10 a.m., in the classroom, revealed the SW was unaware Resident #5 had been attacked by another resident until after the physician's order dated August 22, 2013. Continued interview revealed the SW expected immediate intervention to address the resident's emotional needs following a physical attack. Continued interview revealed the SW had not intervened until August 29, 2013, and confirmed the facility failed to provide medically-related social services for Resident #5 in a timely manner.	F 250	**Measures to be put in place and systemic changes:** **The facility will identify the medically-related social services needs of each resident to assure that the needs are met by the appropriate disciplines. The Director of Nursing and/or Administrator or assigned designee will inform each discipline as needed in a timely manner for initiation of medically related services as identified for each resident. Identification of related services will be communicated during review of incident reports in daily morning administration meeting and by direct communication to appropriate administrative staff following an event or occurrence of an incident.** **Monitoring of corrective actions:** **Monitoring of corrections will be a continued, ongoing program utilizing the morning administration meeting and incident report reviews. Communication of necessary medically related services will be communicated and/or verified at this time. In addition, the Director of Nursing and Administrator will also determine compliance during daily morning meeting and will also utilize direct observation and chart review**	
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 425		

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F 425	Continued From page 20	F 425	samplings. Compliance will also be reviewed monthly as an ongoing monthly agenda item as a part of the monthly QA/QI process beginning 1/2/2014. Director of Nursing will in-service all staff members regarding provisions of the resident abuse policy and reporting requirements as outlined in the policy. In –services will be completed by 1/2/2014, the date allowed under the terms of the 2567.	
	them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.			1-2-14
	This REQUIREMENT is not met as evidenced by: Based on review of facility policy, review of an agreement for pharmacy consulting services, review of facility investigation, review of Medication Destruction Records, review of a Proof of Narcotic Inventory Taken form, and interview, the facility failed to provide pharmacy consultation services to ensure accurate reconciliation and account of all controlled drugs for six residents (#9, #10, #11, #12, #13, #14) of nine residents reviewed. The findings included: Review of facility policy titled, "...Resident Care Policies..." most recently reviewed in January, 2004, revealed, "...Narcotics and other controlled drugs are counted on each shift by one nurse		F 425 Brakebill Nursing and Rehabilitation Center subscribes to the standard that the facility must provide routine and emergency drugs and biological to its residents, or obtain them under an agreement described in §482.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. Corrective actions: No opportunities to retro correct, all medications that were found to be missing were all discontinued whether it be the patient was discharged, medication was changed, or patient expired.	

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F 425	Continued From page 21 coming on shift and one nurse going off shift...Unused or discontinued medication must be removed from the resident's individual medication drawer immediately and returned to the dedicated medication storage area and/or safe for holding for the pharmacy to be destroyed. Narcotics will be destroyed on the premises by the pharmacist and a licensed nurse in each other's presence according to the pharmacists schedule and according to established and recognized pharmacy protocols..." Review of facility policy Number: 140-25-21 most recently reviewed/updated in June, 2012, revealed, "...Subject: Medication Destruction...Reason for destruction...Destruction of controlled medications must be witnssed by a third witness, in addition to the registered nurse and consultant pharmacist..." Review of an Agreement for Pharmacy Consulting Services dated February 7, 2013, revealed, "...Services to be made available monthly...General supervision of the Facility's procedures for the control and accountability for all drugs and biologicals throughout the Facility and that such drugs and biologicals shall be approved and dispensed in compliance with federal and state laws and Facility's own policies and procedures...Assisting in the accounting, destruction, and reconciliation of unused controlled substances and non-controlled substances as required by state and federal law...Review of controlled substances and controlled substances inventory records..." Review of an investigation report dated August 31, 2013, revealed, "On 8-31-13 an inspection for med (medication) destruction...found to be	F 425	**Identification: No other residents in the facility were identified as having the potential to be affected according to the new policy and procedure of collecting and storing narcotics** **Measures to be put in place and systemic changes: Based on the facilities new protocol no unlicensed personnel should handle or administer any drugs whether it be controlled or uncontrolled. All controlled substances are to be collected by the designated nurses (ADON and pharmacy nurse). Upon placing narcotics into safe, all drug sheets and packs are compared to confirm both match accurately. Then they are documented with patients name, drug, dose, and reason for narcotic to be destroyed. Once placed on destruction sheet then the drugs are secured in the safe located in the Beige Wing medication room. The only authorized personnel to know and open the safe are the DON and ADON. Destructions are then done once monthly according to the pharmacist availability. During destruction there are at least three authorized personnel present, the pharmacist, pharmacy nurse, the ADON or DON. Once all narcotics are placed in appropriate container then they are flushed with all three**	

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

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	445114		C 11/19/2013

NAME OF PROVIDER OR SUPPLIER: BRAKEBILL NURSING HOME INC.

STREET ADDRESS, CITY, STATE, ZIP CODE: 5637 LYONS VIEW PIKE, KNOXVILLE, TN 37919

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F 425	Continued From page 22 missing. Approximately 163 pills were found to have been punched out. The medications were also found to be not properly logged in..." Interview with the Pharmacy Liaison Nurse on October 8, 2013, at 1:30 p.m., in the classroom, revealed on September 3, 2013, the facility's owner informed her medications stored for destruction were missing. She stated, "...The meds that were diverted and other meds for destruction were in the front office locked in the billing room in a closet, double-locked...With facility's policy would need to be investigation..." Interview with the Pharmacy Liaison Nurse on October 15, 2013, at 3:07 p.m., in the classroom, revealed a count on September 3, 2013, determined the number of missing pills was 246 (not 163 as reported). Continued interview revealed she was unable to account for the discrepancy between what the facility reported missing and her own count. Continued interview revealed she reported the incident to the facility's pharmacy consultant. Interview and review of Controlled Substance Inventory Records with the Pharmacy Liaison Nurse on October 21, 2013, at 8:45 a.m., in the classroom, revealed the following medications were unaccounted for in the incident of August 31, 2013: Resident #9 - 27 Percocet (schedule II narcotic) 10/325 mg (milligrams); Resident #10 - 14 Alprazolam (anti-anxiety) 0.5 mg; Resident #11 - 9 Morphine Sulfate (schedule II narcotic) 15 mg; Resident #12 - 54 Lortab (schedule II narcotic) 5/500 mg; Resident #13 - 27 Oxycodone/APAP (schedule II narcotic) 10/325 mg; and Resident #14 - 35 Norco (schedule II narcotic) 5/325 mg.; a total of 166 pills, three pills	F 425	personnel's present. Destruction sheets are then signed by all present and a copy is given to the DON to keep a record of all destroyed. Once destruction is completed, the pharmacist then reviews the sheets to make sure each narcotic is accurately accounted for and that the proper destruction measure is checked off on every individual sheet. If any signatures are needed at the time that may have been missed then they are required to be completed as well. The pharmacist in serviced all licensed personnel who are responsible for collecting narcotics and the proper way of documenting on the record sheet prior to placing it into safe. The nursing staff will be in serviced by December 13, 2013 on facility protocol on proper counting of narcotic sheets. Each nurse upon accepting keys is required to count each narcotic sheet delivered from pharmacy. The sheets are located in a narcotic book that is located at each individual medication cart. If any sheets are to be removed for destruction, the nurse removing the sheets is responsible for deducting the number and documenting the reason for removal. If at any time a nurse should find the number of the sheets to not match a book they are required to immediately notify the Director of Nursing and not accept keys until resolved. If at any time the Director of Nursing is unable to	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRAKEBILL NURSING HOME INC.	6837 LYONS VIEW PIKE KNOXVILLE, TN 37919

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F 425	Continued From page 23 more than the facility reported as diverted, and eighty-three fewer pills than identified as unaccounted for by the Pharmacy Nurse Liasison on October 15, 2013, at 3:07 p.m. Review of seven Medication Destruction Records dated August 9, 2013, revealed four of seven records did not identify the method of destruction and the quantity of one of fifty-nine entries was changed from 21 to 19 with no identification regarding the person responsible for changing the number (the number 21 had a line drawn through it). Review of seven Medication Destruction Records dated September 6, 2013, revealed one of sixty entries did not include the quantity destroyed (the medication was illegible) and one of seven pages did not include a third witness signature. Review of a Proof of Narcotic Drug Inventory Taken form for October, 2013, revealed, "Unit: Beige..." Continued review revealed the following: Day Shift October 1, 10, 16, 19 had no signature of the off-going nurse; Day Shift October 15-17 had no signature of the on-coming nurse; Evening Shift October 15-17 had no signature of the off-going nurse or the on-coming nurse; Night Shift October 15-18 had no signature of the off-going nurse; and October 1, 15, 16 had no signature of the on-coming nurse. Telephone interview with the facility's Pharmacy Consultant on October 21, 2013, at 10:55 a.m., revealed medication destruction was completed monthly and the Pharmacy Liaison Nurse monitored for proper documentation of controlled substances. The Pharmacy Consultant stated, "...would expect discrepancy to be picked up at	F 425	resolve problem, the pharmacist will be immediately be notified of possible diversion. Monitoring of corrective actions: Corrective actions are taken by the pharmacist once monthly while destructing narcotics, upon removing drugs and placing them in the proper container the pharmacist reviews each narcotic and compares it to the pack. Once reviewed it is then handed over to the other licensed personnel to discard into an appropriate container. If any discrepancy are discovered the pharmacist will immediately inform the Administrator and Director of Nursing. Compliance will be reviewed in the QA/QI monthly meeting starting 1/02/2014.	

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F 425	Continued From page 24 time destruction meds were picked up... (Pharmacy Liaison Nurse) does monthly QA (quality assurance)...(DON) and I discussed documenting the number of cards...(DON) said nurses weren't doing it right...Nobody there has brought anything about diversion of August 31, 2013, to my attention, no communication from owner or administrator for me to investigate or anything...haven't seen any of the documents regarding events of August 31, 2013. If I had been called...would not have advised them to store controlled substances in location where unauthorized persons had a key." Continued interview revealed the Pharmacy Liaison Nurse's duties in the facility removed the Pharmacy Consultant's responsibility to ensure reconciliation of controlled substances. Continued interview confirmed the facility failed to provide pharmacy consultation services to assure accurate reconciliation and account of all controlled drugs. Interview with the DON and Administrator on November 19, 2013, at 1:40 p.m., in the Administrator's office, confirmed the facility failed to obtain the services of a licensed pharmacist to establish a system of receipt and disposition of controlled drugs to enable accurate reconciliation and account for all controlled drugs.	F 425		1-2-14
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	F 431	F 431 Brakebill Nursing and Rehabilitation Center employs or obtains 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;	

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F 431	Continued From page 25 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 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 review of facility policy, review of an agreement for pharmacy consulting services, review of facility investigation, review of Medication Destruction Records, review of pharmacy delivery sheets, observation, and interview, the facility failed to implement facility policies and procedures to ensure accurate reconciliation and account of all controlled drugs for six residents (#9, #10, #11, #12, #13, #14) of nine residents reviewed, and failed to ensure	F 431	and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Corrective action: No opportunities to retro correct, all medications that were found to be missing were all discontinued whether it be the patient was discharged, medication was changed, or patient expired. Identification: No other residents in the facility were identified as having the potential to be affected according to the new policy and procedure of collecting and storing narcotics Measures to be put in place and systemic changes: The nursing staff will be educated by December 13, 2013 on making sure medications that are being delivered are signed upon verifying each medication to be accurate based on the pharmacy delivery sheet. Pharmacy has been notified that the person responsible for delivering the medications is required to sign the delivery sheet at the time of exchange. Per facility policy all nursing staff will be in	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 431	Continued From page 26 medications were not accessible to unlicensed and unauthorized staff. The findings included: Review of facility policy titled, "...Resident Care Policies..." most recently reviewed in January, 2004, revealed, "...Narcotics and other controlled drugs are counted on each shift by one nurse coming on shift and one nurse going off shift...All medications...shall be properly stored in medicine cabinets, including cabinets on wheels, or drug rooms. Such cabinets or drug rooms shall be kept securely locked when not in use, and the key must be kept in the possession of the supervising nurse or other authorized person. Controlled substances must be stored behind two separately locked doors at all times and accessible only to person in charge of administering medication...Unused or discontinued medication must be removed from the resident's individual medication drawer immediately and returned to the dedicated medication storage area and/or safe for holding for the pharmacy to be destroyed. Narcotics will be destroyed on the premises by the pharmacist and a licensed nurse in each other's presence according to the pharmacists schedule and according to established and recognized pharmacy protocols..." Review of facility policy titled, "Policy for Medication Cart and Medication room Access revised in January, 2005, revealed, "Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications are allowed access to medications. Medication rooms, carts and medication room supplies are locked and attended by persons with authorized access...All medication cart/narcotic	F 431	serviced by December 13, 2013 regarding being required upon accepting keys and counting narcotics to verify and sign that they are the on-going nurse and upon shift change they are to sign the off-going nurse sheet to verify that their count is accurate. Each medication cart contains the narcotic verification sheet that is located in front of every narcotic book. Per facility protocol it is required that two licensed personnel's (DON, ADON, pharmacy nurse) are to be the only authorized individual that can collect narcotics that are required to be destructed. At no time can one of the personnel's collect individually, two are required at all times to review and place in safe that is newly located in the Beige Wing medication room. Prior to placing any controlled substance in the safe, all narcotics are to be documented and counted on a method of destruction record sheet provided by the pharmacy. Upon destruction that is done monthly the method of destruction sheet then again is reviewed by the pharmacist prior to discarding medications. The safe that the narcotics are kept is provided by pharmacy. The Director of Nursing is the only licensed personnel in the facility that has a key to the safe. The other individual who contains the other key is the pharmacist, not one individual is	

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F 431	Continued From page 27 keys are to be kept by the appropriate licensed personnel during his/her shift..." Review of facility policy Number: 140-25-21 most recently reviewed/updated in June, 2012, revealed, "...Subject: Medication Destruction...Reason for destruction...Destruction of controlled medications must be witnssed by a third witness, in addition to the registered nurse and consultant pharmacist..." Review of an Agreement for Pharmacy Consulting Services dated February 7, 2013, revealed, "...Services to be made available monthly...General supervision of the Facility's procedures for the control and accountability for all drugs and biologicals throughout the Facility and that such drugs and biological shall be approved and dispensed in compliance with federal and state laws and Facility's own policies and procedures...Assisting in the accounting, destruction, and reconciliation of unused controlled substances and non-controlled substances as required by state and federal law...Review of controlled substances and controlled substances inventory records..." Review of an investigation report dated August 31, 2013, revealed, "On 8-31-13 an inspection for med (medication) destruction...found to be missing. Approximately 163 pills were found to have been punched out. The medications were also found to be not properly logged in..." Review of the facility's investigation revealed, "Medication Diversion. On 8/31/2013, an inspection and check on scheduled narc's (narcotics) for medication destruction were found to be missing. Medications were secured under	F 431	able to unlock the safe without the other. Both keys to open the safe are required to be present in order for the safe to open. Method of destruction and quantity of medication destroyed. Any changes on the number of medication that is to be destroyed will have a single line drawn through number and error written above line with initial of pharmacist making the correction. Monitoring of corrective actions: Weekly audits will be done by a licensed personnel to ensure that proper documentation on the narcotic verification sheet is completed at the beginning and ending of every shift. Weekly audits will be done by a licensed personnel to ensure that proper documentation on the pharmacy delivery sheet is signed by not only the licensed nurse but by the personnel delivering the medications daily. Compliance will be reviewed in the QA/QI monthly meeting starting 1/02/2014.	

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F 431	Continued From page 28 double lock and in a safe...kept in the Director of Nursing's office...The log that is maintained by the director revealed that some of the medications were not logged in properly..." Review of seven Medication Destruction Records dated August 9, 2013, revealed four of seven records did not identify the method of destruction and the quantity (of medications destroyed) and one of fifty-nine entries was changed from 21 to 19 with no identification regarding the person responsible for changing the number (the number 21 had a line drawn through it). Interview with the Pharmacy Liaison Nurse on October 8, 2013, at 1:30 p.m., in the classroom, revealed she was made aware medications were unaccounted for on September 3, 2013, and the drugs had been removed from the medication carts for destruction. She stated, "...The meds that were diverted and other meds for destruction were...locked in the billing room in a closet, double-locked...With facility's policy would need to be investigation..." Interview with the Assistant Director of Nursing (ADON) on October 15, 2013, at 9:40 a.m., in the classroom, revealed she was made aware medications were unaccounted for by the Pharmacy Nurse Liaison Nurse on September 3, 2013. The ADON stated, "...Three safes in the DON's office...were used for narcotics that were to be destroyed. None of the meds were for any resident in-house..." Continued interview revealed medications for destruction were currently stored in a safe for which she, the DON, and business office staff #1 (an unlicensed person) had the combination.	F 431		

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F 431	Continued From page 29 Interview with the current DON on October 15, 2013, at 10:13 a.m., in the classroom, revealed she was present in the facility on August 31, 2013, and observed medications, controlled substances inventory records, and empty medication cards in a box stored in a closet in the former DON's office. Continued interview revealed there was no inventory of the controlled substances and records discovered in the closet on August 31, 2013, and the controlled substance records and medication cards containing controlled substances were taken from the DON's office and looked in a closet in the billing office. Interview with business office staff #1 on October 15, 2013, at 11:25 a.m., in the classroom, revealed the controlled medications found in the DON's office on August 31, 2013, were locked in the billing office from August 31, 2013, at approximately 10:30 a.m., until the morning of September 2, 2013, and she, an unauthorized person, had possession of a key that provided access to the controlled medications. Interview with the Pharmacy Liaison Nurse on October 15, 2013, at 3:07 p.m., in the classroom, revealed a count on September 3, 2013, determined the number of missing pills was 246 (not 163 as reported). Continued interview revealed she was unable to account for the discrepancy between what the facility reported missing and her own count. Continued interview revealed she reported the incident to the facility's pharmacy consultant. Interview and review of Controlled Substance Inventory Records with the Pharmacy Liaison Nurse on October 21, 2013, at 8:45 a.m., in the classroom, revealed the following medications	F 431		

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F 431	Continued From page 30	F 431		

were unaccounted for in the incident of August 31, 2013: Resident #9 - 27 Percocet (schedule II narcotic) 10/325 mg (milligrams); Resident #10 - 14 Alprazolam (anti-anxiety) 0.5 mg; Resident #11 - 9 Morphine Sulfate (schedule II narcotic) 15 mg; Resident #12 - 54 Lortab (schedule II narcotic) 5/500 mg; Resident #13 - 27 Oxycodone/APAP (schedule II narcotic) 10/325 mg; and Resident #14 - 35 Norco (schedule II narcotic) 5/325 mg; a total of 166 pills, three pills more than the facility reported as diverted, and eighty three fewer pills than identified as unaccounted for by the Pharmacy Nurse Liasison on October 15, 2013, at 3:07 p.m.

Review of Consolidated Delivery Sheets dated July 11, 2013, through October 15, 2013, revealed nine of thirty-four sheets had no signature of the person authorized to receive deliveries. Continued review revealed the nine deliveries included controlled medications.

Observation of a narcotic count book on the 100 hall on October 18, 2013, at 9:00 a.m., revealed the on-coming nurse, Licensed Practical Nurse (LPN) #1, had not signed to verify accuracy of the narcotic count.

Interview with LPN #1 on October 18, 2013, at 9:00 a.m., in the hallway at Room 104, revealed LPN #1 had been trained to sign for accuracy of the count at the time the count was completed.

Observation of three nursing card count forms on October 18, 2013, between 9:20 a.m. and 10:30 a.m., revealed two oncoming nurses had not signed for accuracy and only one nurse had signed as the offgoing nurse on October 18, 2013.

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BRAKEBILL NURSING HOME INC.	5837 LYONS VIEW PIKE KNOXVILLE, TN 37919

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F 431	Continued From page 31 Review of four nursing card count forms for October 21, 2013, revealed three of four oncoming nurses had not signed for accuracy and one nurse had signed as the offgoing nurse in advance of the count. Review of a Proof of Narcotic Drug Inventory Taken form for October, 2013, revealed, "Unit: Beige..." Continued review revealed the following: Day Shift October 1, 10, 16, 19 had no signature of the off-going nurse; Day Shift October 15-17 had no signature of the on-coming nurse; Evening Shift October 15-17 had no signature of the off-going nurse or the on-coming nurse; Night Shift October 15-18 had no signature of the off-going nurse; and October 1, 15, 16 had no signature of the on-coming nurse. Interview with LPN #4 on October 21, 2013, at 10:40 a.m., in the 300 hallway, revealed each hallway had two medication carts and she had failed to sign for accuracy of the count at the time of the count. Interview with LPN #5 on October 21, 2013, at 10:45 a.m., in the 100 hallway, revealed LPN #5 had signed for accuracy as the offgoing nurse prior to the count. Telephone interview with the facility's Pharmacy Consultant on October 21, 2013, at 10:55 a.m., revealed medication destruction was completed monthly, the Pharmacy Liaison Nurse monitored for proper documentation of controlled substances and she stated, "...would expect discrepancy to be picked up at time destruction meds were picked up...(Pharmacy Liaison Nurse) does monthly QA (quality assurance)...(DON) and	F 431		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445114		C 11/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRAKEBILL NURSING HOME INC.	5837 LYONS VIEW PIKE KNOXVILLE, TN 37919

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F 431	Continued From page 32 I discussed documenting the number of cards... (DON) said nurses weren't doing it right...Nobody there has brought anything about diversion of August 31, 2013, to my attention, no communication from owner or administrator for me to investigate or anything...haven't seen any of the documents regarding events of August 31, 2013. If I had been called...would not have advised them to store controlled substances in location where unauthorized persons had a key." Continued interview revealed the Pharmacy Liaison Nurse's duties in the facility removed the Pharmacy Consultant's responsibility to ensure reconciliation of controlled substances. Interview with the DON and Administrator on November 19, 2013, at 1:40 p.m., in the Administrator's office, confirmed the facility failed to obtain the services of a licensed pharmacist to establish a system of receipt and disposition of controlled drugs to enable accurate reconciliation and account for all controlled drugs, and failed to store all drugs in locked compartments for which only authorized persons had access to the keys.	F 431		