

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

Otc 12/6/13

PRINTED: 10/22/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <b>Poc # 1</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445131</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEVERLY PARK PLACE HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5321 BEVERLY PARK CIRCLE KNOXVILLE, TN 37918</b>		
(X4) ID PREFIX TAG <b>F 281 SS-D</b>	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG <b>F 281</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE <b>11-04-13</b>	
	<p><b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b></p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of facility policy, observation, and interview, the facility failed to administer medication in accordance with the physician's orders for one resident (#9) of thirteen sampled residents.</p> <p>The findings included:</p> <p>Review of facility policy titled Administering Medications most recently revised in April 2007, and provided by the Director of Nursing on September 29, 2013, revealed, "...Medications will be administered in a safe and timely manner, and as prescribed...Medications must be administered in accordance with the orders, including any required time frame...The individual administering the medication must check the label THREE (3) times to verify the right medication, right dosage, right time...before giving the medication...must initial the resident's MAR (Medication Administration Record) on the appropriate line after giving each medication..."</p> <p>Resident #9 was admitted to the facility on August 11, 2013, with diagnoses including Chronic Pain and Rheumatoid Arthritis.</p> <p>Medical record review of physician orders dated August 11, 2013, revealed, "...Mirax Powder...34 gm (grams) (cap is measure) in 16</p>		<p><b>F-281</b></p> <p><u>1.</u> Resident # 9 was assessed by the Assistant Director of Nursing on 09/29/2013 with no negative outcome. The physician was notified and a telephone order was received on 09/29/2013. Resident is self responsible and was aware on 09/29/2013. Registered Nurse # 1 was inserviced by the Assistant Director of Nursing on medication administration on 09/29/2013. A med pass observation was completed with Registered Nurse # 1 by the Assistant Director of Nursing on 09/29/2013.</p> <p><u>2.</u> A 100% audit of all Miralax and Requip orders was completed by the Director of Nursing, Assistant Director of Nursing and Unit Managers from 10/01/2013-10/03/2013. No residents were identified to be affected.</p> <p><u>3.</u> Licensed Nursing staff were in-serviced on 09/29/2013-10/04/2013 by the Director of Nursing and/or Staff Development Coordinator on medication administration.</p> <p><u>4.</u> All new telephone and admission orders for requip and miralax will be audited in the am meeting by the Director of Nursing, Assistant Director of Nursing and/or Unit Managers x 3 months. A med pass observation will be conducted with 10% of licensed nurses every week x 3 months. Results of the findings will be reported to the Quality Assurance Performance Improvement Committee x 3 months or until 100% compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Therapy Manager, Staff Development Coordinator, Social Services Department, MDS Coordinators, Maintenance Director, Laundry Director, Admissions Director, Business Office Manager, Housekeeping Director, Medical Records, Dietary Manager, Activity Director, and Medical Director.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Doretha Williamson*

*Administrator*

*10-30-13*

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 281	Continued From page 1 ozs (ounces) of water and take by mouth daily...Ropinirole...3 mg (milligrams)...take 1 tablet by mouth 2 times daily 3PM (3:00 p.m. 8 PM (8:00 p.m.)..."  Observation and interview with Registered Nurse (RN #1) on September 29, 2013, at 10:02 a.m., revealed Registered Nurse (RN #1) administered Miralax 17 grams in approximately six ounces of water and Ropinirole 3 mg. to Resident #9.  Review of the Medication Administration Record (MAR) and interview with RN #1 on September 29, 2013, at 11:23 a.m. in the main floor medication room, revealed the nurse had not initialed Ropinirole, and confirmed the medications had not been administered in accordance with the physician's orders.	F 281			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on medical record review, review of a facility investigation, observation, and interview, the facility failed to provide adequate supervision to prevent a fall for one resident (#3) of thirteen sampled residents.	F 323	F-323  1. Resident #3 was assessed by the Charge Nurse on 07/14/2013 and by the Nurse Practitioner on 07/16/2013 with no negative outcome. The physician was notified on 07/14/2013 and a telephone order was received. The family was also notified on 07/14/2013. Resident #3 was evaluated by Physical Therapist for appropriate lift sling on 07/15/2013. The mechanical lift and the lift sling were evaluated by the Director of Facilities Management on 07/15/2013. Nurse Aides #1 and #2 were inserviced on proper use of the total mechanical lift on 07/15/2013 by the Director of Nursing and Unit Manager.  2. A 100% audit of resident lift assessments was completed 07/15/2013 – 07/18/2013 by the Director of Nursing, Assistant Director of Nursing and Unit Managers. No residents were found to be affected.	11-04-13	

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F 323	<p>Continued From page 2</p> <p>The findings included:</p> <p>Resident #3 was admitted to the facility on June 7, 2011, with diagnoses including Dementia with Behavioral Disturbance and Abnormality of Gait.</p> <p>Medical record review of a Minimum Data Set dated July 9, 2013, revealed the resident required assistance of two staff for transfers and had no history of falls.</p> <p>Medical record review of a mechanical lift assessment form dated May 17, 2013, revealed, "...total lift required..."</p> <p>Medical record review of a care plan dated July 11, 2013, revealed, "...transfer...via total lift..."</p> <p>Medical record review of a physician's order dated July 14, 2013, revealed, "Ice to bump on the head x (for) 24 hrs (hours)..."</p> <p>Review of a facility investigation report dated July 14, 2013, revealed, "...fell bump on head...Reported by (Certified Nursing Assistant - CNA #1)..."</p> <p>Review of a witness statement by CNA #1 dated July 14, 2013, revealed, "(CNA #2) and I...changed (resident) and put the lift under (resident) and hooked (resident) up to the...lift...was positioning over the chair... (resident) came out of the lift..."</p> <p>Review of a witness statement by CNA #2 dated July 14, 2013, revealed, "(CNA #1) and I went...to change (resident) and to get (resident) out of bed. We hooked the sling onto the lift...lifted (resident)</p>	F 323	<p>3. Nursing staff were re-inserviced on proper use of the total mechanical lift by the Director of Nursing, Assistant Director of Nursing, Unit Managers, and Staff Development Coordinator on 07/15/2013-08/05/2013.</p> <p>4. 10% of nurse aides will be observed for proper utilization of the total mechanical lift weekly x 3 months by the Director of Nursing, Assistant Director of Nursing and/or Unit Managers. Results of the findings will be reported to the Quality Assurance Performance Improvement Committee x 3 months or until 100% compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Therapy Manager, Staff Development Coordinator, Social Services Department, MDS Coordinators, Maintenance Director, Laundry Director, Admissions Director, Business Office Manager, Housekeeping Director, Medical Records, Dietary Manager, Activity Director, and Medical Director.</p>		

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F 323	Continued From page 3 off the bed moved the lift away from the bed. As we were moving the lift toward (resident's) chair (resident) fell out of the sling onto the floor..."  Review of a facility investigation report dated July 14, 2013, revealed, "...3 of 4 sling straps connected..."  Medical record review of a Nurse Practitioner's note dated July 16, 2013, revealed, "F/U S/P. (follow up after) fall on 7-14-13. Neuro intact no hematoma...no significant trauma..."  Observation on September 29, 2013, at 1:23 p.m., revealed the resident seated in a wheelchair in the resident's room and two CNAs assisted the resident with oral hygiene.  Interview with CNA #1 on September 30, 2013, at 10:32 a.m., at a first floor nurse's station, revealed, "...after we cleaned (resident) we put lift pad under (resident)...positioned lift over (resident) to fasten it into lift. We buckled (resident) in..." Continued interview confirmed the resident fell from the lift during the transfer from the bed to a wheelchair on July 14, 2013.	F 323		
F 441 SS=D	C/O: #32057 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program	F 441	F-441  Residents in room 102 were assessed by the Nurse Practitioner on 10/01/2013 with no negative outcome. Certified Nurse Aide #1 was inserviced on proper handling and transportation of soiled linen on 10/01/2013 by the Staff Development Coordinator and/or Director of Nursing.	11-04-13

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F 441	<p>Continued From page 4</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of facility policy, observation, and interview, the facility failed to transport linen to prevent the spread of infection on one floor (first) of four floors.</p> <p>The findings included:</p>	F 441	<p>2. The Staff Development Coordinator completed competency check offs for all certified nursing assistants on the handling and transporting of soiled linen on 10/22/2013 - 11/04/2013.</p> <p>3. The Director of Nursing and/or Staff Development Coordinator re-instructed nursing staff on proper handling and transportation of soiled linen on 10/01/2013-11/04/2013.</p> <p>4. 10% of certified nursing assistants will be observed for proper handling and transportation of soiled linen weekly x 3 months by the Director of Nursing, Assistant Director of Nursing, and/or Unit Managers. Results of the findings will be reported to the Quality Assurance Performance Improvement Committee x 3 months or until 100% compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Therapy Manager, Staff Development Coordinator, Social Services Department, MDS Coordinators, Maintenance Director, Laundry Director, Admissions Director, Business Office Manager, Housekeeping Director, Medical Records, Dietary Manager, Activity Director, and Medical Director.</p>	

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F 441	<p>Continued From page 5</p> <p>Review of an undated facility policy provided by the Director of Nursing (DON) on October 1, 2013, and titled Linen Storage revealed, "...All personnel handling linen will follow linen storage guidelines...All contaminated laundry will be placed in specially marked laundry containers to reduce leakage...Soiled linen will be held away from the body and transported directly to the appropriate linen hamper. Never place soiled linen on the floor. Transport in the linen bag..."</p> <p>Observation on September 29, 2013, at 9:32 a.m., revealed Certified Nursing Assistant (CNA) #1 exited Room 104, carried a plastic bag filled with white material in each hand and walked past room 102. Continued observation revealed CNA #1 turned around, carried the bags, and entered Room 102.</p> <p>Interview with CNA #1 on September 29, 2013, at 9:35 a.m., revealed one bag contained bed linen used by a resident in Room 104 and the other contained soiled briefs. Continued interview revealed the CNA was aware of the appropriate method for handling used linen and soiled briefs.</p> <p>Interview with the Director of Nursing (DON) on October 1, 2013, at approximately 1:00 p.m., in the DON's office, confirmed the facility failed to transport linen in a manner to prevent the spread of infection.</p>	F 441			