

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

PRINTED: 03/29/2011
FORM APPROVED
OMB NO. 0938-0391

45th 5/28/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/24/2011
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NAME OF PROVIDER OR SUPPLIER BLED SOE COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155 SS=D	<p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain advanced directive information for one resident (#8) of fifteen residents reviewed.</p> <p>The findings included:</p> <p>Resident #8 was admitted to the facility on June 22, 2009, and readmitted on March 25, 2010, with diagnoses including Chronic Obstructive Pulmonary Disease, Arteriosclerotic Cardiovascular Disease, Atrial Fibrillation and Chronic Pain.</p> <p>Medical record review of the Minimum Data Set (MDS) dated July 11, 2010, revealed the resident was a DNR (Do Not Resuscitate) status. Medical record review of the MDS dated January 11, 2011, revealed the resident's Brief Interview for Mental Status (cognitive status) was one out of fifteen (fifteen being highest cognitive status).</p> <p>Medical record review of the Social Services notes from admission to the present revealed no documentation of addressing advanced directive information with a responsible party.</p> <p>Medical record review of the Patient Care Plan</p>	F 155	<p>F 155</p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>A current POST form will be completed by surrogate designated by the physician. Meeting will be scheduled with the surrogate and other family members on 4/12/11 with the Social Services Director and the MDS Coordinator.</p> <p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>All charts were reviewed on 3/30/11 by the Social Services Director. Any updates or corrections needing to be made are currently in process and will be completed no later than 4/30/11.</p>	4/30/11 4/30/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Stephanie Bynette</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4/7/11</i>
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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 155 SS=D	<p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain advanced directive information for one resident (#8) of fifteen residents reviewed.</p> <p>The findings included:</p> <p>Resident #8 was admitted to the facility on June 22, 2009, and readmitted on March 25, 2010, with diagnoses including Chronic Obstructive Pulmonary Disease, Arteriosclerotic Cardiovascular Disease, Atrial Fibrillation and Chronic Pain.</p> <p>Medical record review of the Minimum Data Set (MDS) dated July 11, 2010, revealed the resident was a DNR (Do Not Resuscitate) status. Medical record review of the MDS dated January 11, 2011, revealed the resident's Brief Interview for Mental Status (cognitive status) was one out of fifteen (fifteen being highest cognitive status).</p> <p>Medical record review of the Social Services notes from admission to the present revealed no documentation of addressing advanced directive information with a responsible party.</p> <p>Medical record review of the Patient Care Plan</p>	F 155	<p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>All charts will be reviewed initially and during quarterly reviews or condition changes to identify the need for verification and updating of the POST by the Social Services Director and the MDS Coordinator.</p>	4/30/11
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F 155 SS=D	<p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain advanced directive information for one resident (#8) of fifteen residents reviewed.</p> <p>The findings included:</p> <p>Resident #8 was admitted to the facility on June 22, 2009, and readmitted on March 25, 2010, with diagnoses including Chronic Obstructive Pulmonary Disease, Arteriosclerotic Cardiovascular Disease, Atrial Fibrillation and Chronic Pain.</p> <p>Medical record review of the Minimum Data Set (MDS) dated July 11, 2010, revealed the resident was a DNR (Do Not Resuscitate) status. Medical record review of the MDS dated January 11, 2011, revealed the resident's Brief Interview for Mental Status (cognitive status) was one out of fifteen (fifteen being highest cognitive status).</p> <p>Medical record review of the Social Services notes from admission to the present revealed no documentation of addressing advanced directive information with a responsible party.</p> <p>Medical record review of the Patient Care Plan</p>	F 155	<p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>This will be monitored through chart reviews with the Social Services Director and the MDS Coordinator and through QA Committee for 6 months or as deemed necessary by the QA Committee.</p> <p>QA Committee: Director of Nursing; MDS Coordinator; Dietary Supervisor; Social Services Director; Administrator; Pharmacist; Medical Director; Floor Nurse and C.N.A.</p> <p><i>Chart reviews will be 1 x wk for 6 mos. OR as deemed necessary</i></p>	<p>4/30/11</p> <p><i>how often monitor? ex: 2x week x</i></p>
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F 155	Continued From page 1 review dated October 13, 2009, January 13, 2010, March 25, 2010, and April 13, 2010, revealed the resident's "...Code status: DNR...or NO CPR..." Interview, with the Social Worker on March 24, 2011, at 9:50 a.m. and 3:15 p.m., in the Social Worker's office, confirmed the social worker failed to obtain the Physician Orders for Scope of Treatment (POST) at admission. Further interview confirmed the social worker failed to periodically check the advanced directive status of the resident. Further interview revealed the responsible party was contacted and confirmed the DNR status was appropriate.	F 155		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to assess one resident (#13) of fifteen residents reviewed for self-administration of medications. The findings included: Resident #13 was admitted to the facility on January 4, 2011, with diagnoses including Hypertension and Hyperthyroidism. Medical record review of the Minimum Data Set	F 176	F <u>176</u> 1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE? Medications were removed from resident #13's room by 7-3 charge nurse on 3/22/2011	4/30/11

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F 176	<p>Continued From page 2 (MDS) dated January 17, 2011, revealed the resident scored fourteen out of fifteen (fifteen being the highest cognitive status) on the Brief Interview for Mental Status (cognitive status).</p> <p>Medical record review revealed no documentation the resident had been assessed for self-administration of medications.</p> <p>Medical record review of the Physician's Recapitulation Orders dated March 2011, revealed, "...Self Administration of Meds...No..."</p> <p>Review of the facility's "Resident Self-Administration of Drugs" policy revealed, "...If the resident expresses a desire to self-administer drugs, the attending physician will be notified. The interdisciplinary team, including the attending physician, will assess the resident to determine if this practice is safe..."</p> <p>Observation and interview with the resident on March 22, 2011, at 10:35 a.m., revealed a thick, pink paste filled approximately 75 percent of a plastic 30 milliliter medicine cup, and was placed on top of a clear container of candy, on the resident's bedside table. The resident confirmed, "...I put it (the paste) on my hemorrhoids...it's hemorrhoid cream...the nurse gave it to me (paste in medicine cup)..."</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on March 22, 2011, at 10:45 a.m., in the resident's room, confirmed the paste in the medicine cup was Calmoseptine Ointment (a moisture barrier that prevents and helps heal skin irritations). Continued interview confirmed the ointment did not belong in the resident's room and LPN #1 removed the ointment and discarded</p>	F 176	<p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>Residents were reviewed by the Director of Nurses to identify any potential residents who wishes to administer their own medications. All resident's rooms were visually searched by the C.N.A's and charge nurses on 3/22/11 for any other medications including creams.</p>	4/30/11
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F 176	<p>Continued From page 2</p> <p>(MDS) dated January 17, 2011, revealed the resident scored fourteen out of fifteen (fifteen being the highest cognitive status) on the Brief Interview for Mental Status (cognitive status).</p> <p>Medical record review revealed no documentation the resident had been assessed for self-administration of medications.</p> <p>Medical record review of the Physician's Recapitulation Orders dated March 2011, revealed, "...Self Administration of Meds...No..."</p> <p>Review of the facility's "Resident Self-Administration of Drugs" policy revealed, "...If the resident expresses a desire to self-administer drugs, the attending physician will be notified. The interdisciplinary team, including the attending physician, will assess the resident to determine if this practice is safe..."</p> <p>Observation and interview with the resident on March 22, 2011, at 10:35 a.m., revealed a thick, pink paste filled approximately 75 percent of a plastic 30 milliliter medicine cup, and was placed on top of a clear container of candy, on the resident's bedside table. The resident confirmed, "...I put it (the paste) on my hemorrhoids...it's hemorrhoid cream...the nurse gave it to me (paste in medicine cup)..."</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on March 22, 2011, at 10:45 a.m., in the resident's room, confirmed the paste in the medicine cup was Calmoseptine Ointment (a moisture barrier that prevents and helps heal skin irritations). Continued interview confirmed the ointment did not belong in the resident's room and LPN #1 removed the ointment and discarded</p>	F 176	<p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>Any new residents who are admitted to the facility will be evaluated by the admitting nurse for the potential of administering their own medication using the form: "Evaluation for Self-Administration of Medications". This will begin 4/4/2011 Inservice was conducted 4/4/2011 by the Director of Nursing</p> <p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>The Director of Nursing or the MDS Coordinator will review all new admit's charts to ensure forms are completed. This will be monitored by the QA committee for 6 months or until committee deems necessary.</p>	4/30/11 4/30/11

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F 176	Continued From page 3 it in the trash can on the medication cart.	F 176	QA Committee: Director of Nursing; MDS Coordinator; Dietary Supervisor; Social Services Director; Administrator; Pharmacist; Medical Director; Floor Nurse and C.N.A.		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to complete the pre-restraint assessment for one resident (#10); failed to perform pre-restraint and quarterly assessments for one resident (#11); and failed to acquire consents for restraint use for three residents (#9, #10, #11) of fifteen residents reviewed. The findings included: Resident # 9 was admitted to the facility on September 1, 2006, with diagnoses including Cerebral Palsy, Mental Retardation, and Hypertension. Review of the Minimum Data Set (MDS) dated March 3, 2011, revealed the resident had short and long term memory impairment, severe cognitive impairment, required extensive assistance with transfers, was non-ambulatory, and utilized a trunk restraint.	F 221			

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F 221	<p>Continued From page 4</p> <p>Medical record review revealed no documentation the consent for restraint use had been obtained. Review of the Pre-Restraining Assessment dated September 1, 2006, revealed the resident had been evaluated for the use of a lap buddy, a soft, padded device positioned between the armrests of the wheelchair.</p> <p>Observation on March 23, 2011, at 4:00 p.m., revealed the resident seated in the wheelchair with the lap buddy placed between the armrests of the wheelchair.</p> <p>Interview with the Director of Nursing (DON) on March 23, 2011, at 4:30 p.m., in the DON's office confirmed the facility had not obtained the consent for restraint use for resident # 9.</p> <p>Resident #10 was admitted to the facility on September 23, 2008, with diagnoses including Alzheimer's Dementia, Osteoarthritis, and Diabetes Mellitus. Review of the Minimum Data Set (MDS) dated January 6, 2011, revealed the resident required extensive assistance of two persons for transfers, was non-ambulatory, and had bilateral limited range of motion of the lower extremities. Continued review of the same MDS revealed the resident used a chair that prevented rising.</p> <p>Medical record review revealed no documentation the facility had obtained consent for restraint use for resident #10.</p> <p>Observation on March 24, 2011, at 9:30 a.m., revealed the resident in a geri-chair, slightly reclined with a table top tray across the arms on the chair. Continued observation revealed the resident's hands and forearms were resting on</p>	F 221	<p>F 221</p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>Resident #9: Restraint consent will be obtained for the use of "lap buddy" by 4/30/11</p> <p>Resident #10: Restraint consent was obtained for the use of Geri-chair. A new "Pre-restraining Assessment was performed by the charge nurse on 4/4/11.</p> <p>Resident #11: A new "Pre-restraining Assessment was completed by the change nurse on 4/4/2011. The Pummal Cushion was removed as a "restraint" and documented as "an enabler" (as residents is unable to get out of wheelchair by himself even without the cushion in place) by the MDS Coordinator on the MDS as well as the C.N.A. worksheets.</p>	4/30/11
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F 221	<p>Continued From page 5 the table top.</p> <p>Review of the Pre-Restraining Assessment for resident #10 revealed the resident had balance problems and had been assessed as "falls/leans sideways to the left and to the right." Continued review of the Pre-Restraining Assessment revealed the interdisciplinary team evaluation had not been completed, signed, and dated by the facility representative.</p> <p>Interview with the MDS Coordinator on March 24, 2011, at 11:30 a.m., in the MDS Coordinator's office confirmed the Pre-Restraining Assessment was incomplete.</p> <p>Interview with the Director of Nursing (DON) on March 23, 2011, at 4:30 p.m., in the DON's office confirmed the facility had not obtained the consent for restraint use for resident # 10.</p> <p>Resident #11 was admitted to the facility on June 4, 2010, with diagnoses including Post Cardiovascular Accident (Stroke), Hypertension, and Dementia.</p> <p>Medical record review of the Physician's Recapitulation Orders dated March 2011, revealed "...Wedge cushion when up in wheelchair..."</p> <p>Medical record review of the resident's current care plan revealed, "...Problem: Resident requires use of wedge cushion when up in wc (wheelchair) for safety d/t (due to) leans and inability to rebalance self...Goal: Resident's use of the cushion will be eliminated...Approach: Use least restrictive type of restraint parcticle (practical)...may remove restraint when under</p>	F 221	<p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>The 802 was reviewed by the Director of Nursing on 3/31/11 and updated to corrected identify the use of "restraints" on residents. Charts will be reviewed by the Director of Nursing for evidence of the "Pre-Restraining Assessment" This will be accomplished by 4/30/11</p> <p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>An inservice was conducted 4/4/2011 by the Director of Nursing. The MDS Coordinator will re-assess each resident requiring restraints quarterly for potential of reduction and/or elimination. Restraint Consents will be obtained on all residents identified as requiring restraints by 4/30/11</p>	<p>4/30/11</p> <p>4/30/11</p> <p><i>For who & what?</i></p> <p><i>who will do?</i></p>

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F 221	Continued From page 6 direct supervision by staff or family...reassess need for restraints at least quarterly and prn (as needed)...assess & (and) explore alternatives; document findings; obtain order and/or permission to implement..." Medical record review of the resident's "Pre-Restraining Assessment" revealed the assessment was blank (not completed). Medical record review revealed no signed consent for the use of the wedge cushion. Medical record review revealed no documentation of re-assessment of the restraint for reduction and/or elimination. Observation on March 23, 2011, at 4:00 p.m., in the dining room, revealed the resident sitting in a wheelchair with a wedge foam pommel cushion in the seat of the wheelchair. Interview with the Director of Nursing (DON) on March 23, 2011, at 4:15 p.m., at the nursing station, confirmed the facility failed to complete a pre-restraint assessment for the least restrictive intervention; failed to obtain consent to use the restraint; and failed to re-assess the restraint for reduction and/or elimination at least quarterly and prn for the resident.	F 221	4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? The Director of Nursing or the MDS Coordinator will review the chart of any resident who requires the use of a restraint for the signed "Restraint Consent". The Director of Nursing will monitor for completion of "Restraint Reduction/ Elimination" form. This will be monitored by the QA Committee for 6 months or as deemed necessary by the QA Committee.	<i>how know which charts?</i> 4/30/11
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		<i>frequency?</i>

APR 08 2011

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER BLEDSOE COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367
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F 309	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, facility document review, policy review, and interview, the facility failed to assess for pain for one resident (#5) of fifteen residents reviewed.</p> <p>The findings included:</p> <p>Resident #5 was admitted to the facility on May 14, 2010, with diagnoses including Osteoarthritis, Congestive Heart Failure and Chronic Pain Syndrome.</p> <p>Medical record review of the Minimum Data Set (MDS) dated February 24, 2011, revealed the resident received scheduled and as needed pain medication. Further review revealed the pain was experienced frequently with an intensity of eight out of ten (ten being the worst pain imaginable) and a verbal description of "...very severe, horrible..."</p> <p>Medical record review of the "Initial Pain Assessment Tool" dated May 14, 2010, revealed "...Location (of the pain): (no) c/o (complaints) of pain at this time. Hx: neck, bil (bilateral) leg, back, bil shoulder...Intensity: (0-10 scale) not present, worse pain gets 8...What relieves pain: "pain pill I get 3 times a day"...Plan: Hydrocodone-APAP 5/500 one po TID (by mouth three times daily)..."</p> <p>Medical record review of the physician order initiated on May 14, 2010, to the present date, revealed "...Hydrocodone (pain</p>	F 309	<p>F 309</p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>Medications for Resident #5 were reviewed by the Physician on 3/30/11. Resident's medications were changed from PRN to routine on that day. Resident #5 was assessed using "Pain Assessment Monitor" form by the Charge Nurse on 4/4/2011.</p> <p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>All resident's MARs and Medications were reviewed and discussed by the Charge Nurses and Director of Nursing on 4/4/2011.</p>	<p>4/4/11</p> <p>4/4/11</p>
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APR 08 2011

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F 309	<p>Continued From page 8 medication)...5/500 take one tablet every 8 hours as needed (PRN) for pain..."</p> <p>Medical record review of the Medication Administration Record (MAR) for February 2011, revealed daily PRN Hydrocodone administrations documented except for February 1, 4, and 15. Further review the PRN Hydrocodone administration times documented revealed one administration at 7:00 a.m.; ten administrations between 8:00 and 9:00 a.m.; one administration at 10:00 a.m.; one administration at 6:00 p.m.; seventeen administrations between 7:30 and 8:00 p.m.; and one administration at 9:00 p.m.</p> <p>Medical record review of the MAR for March 1-23, 2011, revealed daily PRN Hydrocodone administrations documented. Further review the PRN Hydrocodone administration times documented revealed one each administration at 3:00 a.m., 6:00 a.m., 7:00 a.m.; twelve administrations between 8:00 and 9:00 a.m.; one administration at 10:00 a.m.; one administration at 2:30 p.m.; eleven administrations between 7:30 and 8:00 p.m.; and one administration at 10:15 p.m.</p> <p>Medical record review of the care plan initiated June 2, 2010, to the present date, revealed the "...resident voices repetitive health complaints...Goal: resident's repetitive expressions of concern regarding health problems: has daily complaints of pain R/T (related to) Osteoarthritis...Approaches: 1) Assess factual basis for complaint attempt to resolve and/or alleviate any related discomfort...8) Administer Hydrocodone 5/500 3 times a day as needed for pain..."</p>	F 309	<p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>Inservice was conducted by the Director of Nursing on 4/4/2011. "Pain Assessment Monitor" form will be completed on all new admissions by the admitting nurse beginning 4/4/2011. Also "Pain Evaluation" form will be completed on all residents upon hospital return or with significant change in condition but the admitting nurse. Staff will begin using the "Wong Baker Pain Scale" beginning 4/4/2011 to describe the intensity of resident's pain and to evaluate the effectiveness of the pain medication when used PRN. A copy of the "Wong Baker Pain Scale" will be placed in the MAR as well as the treatment book. Charge Nurses not present at the meeting will be required to read the minutes and sign the sign-in sheet with the date that they read the minutes. New nurses will be instructed as part of their orientation by the charge nurse.</p>	4/4/11 <i>Just for chg nurses?</i>
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F 309	<p>Continued From page 9</p> <p>Review of the facility policy for "Pain Assessment" revealed the "...Purpose: To correctly assess a resident's level of pain and provide appropriate intervention to control/prevent pain...Procedure: Upon admission, each resident will be assessed for complaints of pain by the ADON (Assistant Director of Nursing) or the charge nurse. The results will be placed in the resident's medical record. The cause and methods of pain control will be documented in the care plan..."</p> <p>Review of the facility policy for "Physician Notification of Change in Resident Status Policy" revealed the "...Purpose: To establish guidelines to inform the nurse when a physician must be notified...Procedure: The physician will be notified of the following unless otherwise ordered: 2. A physician will be notified when a doctor's order needs clarification...14. Any other circumstances as indicated by resident's behavior, condition or status warrants (warrants)..."</p> <p>Interview, with Licensed Practical Nurse (LPN) #3, on March 24, 2011, at 8:00 a.m., in the hall by room 126, confirmed the Medication Administration Record Nurse's Medication Notes for December 2010 through March 2011, did not document the level of pain at the time of the administration of the medication or as part of the effectiveness. Further interview confirmed there was no documentation the pain level was assessed. Further interview confirmed the physician had not been notified of the daily administration of the PRN Hydrocodone in February and March 2011, due to the "...different times of the administration and no pattern established...."</p>	F 309	<p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>The Director of Nursing or the MDS Coordinator will review all new admissions and hospital returns for completed forms.</p> <p>This will be monitored by the QA Committee for 6 months or as deemed necessary by the QA Committee.</p> <p>QA Committee: Director of Nursing; MDS Coordinator; Dietary Supervisor; Social Services Director; Administrator; Pharmacist; Medical Director; Floor Nurse and C.N.A.</p> <p>QA Committee: Director of Nursing; MDS Coordinator; Dietary Supervisor; Social Services Director; Administrator; Pharmacist; Medical Director; Floor Nurse and C.N.A.</p>	4/4/11
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F 309	Continued From page 10 Interview, with the Director of Nursing (DON) in the chapel on March 24, 2011, at 8:27 a.m., confirmed the facility assessed pain only at admission and not at readmission. Further interview confirmed there was no ongoing assessment or tracking of pain. Further interview confirmed the physician had not been notified regarding the daily Hydrocodone administration in February and March 2011. Further interview revealed the MDS Coordinator assessed the pain as part of the MDS review.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced	F 315	F 315 1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE? Resident #1 was assessed for the need of a foley catheter upon hospital return on 3/30/11 by the admitting nurse. Resident #6 has had her foley discontinued on 11/10/2010.	4/4/11 <i>what was the medication? Justification?</i>

APR 08 2011

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F 315	<p>Continued From page 11</p> <p>by: Based on medical record review, observation, and interview, the facility failed to provide medical justification and assessment for indwelling catheter usage for two residents (#1, #6) of fifteen residents reviewed.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on July 7, 2010, with diagnoses including Alzheimer's Disease, Chronic Obstructive Pulmonary Disease, Hypertension, and Tremors. Resident #1 was readmitted to the facility on March 3, 2011, with diagnoses including Urinary Tract Infection and Dehydration.</p> <p>Review of the Minimum Data Set (MDS) dated January 20, 2011, revealed the resident had significant cognitive impairment, required extensive assistance for transfers, was non-ambulatory, and was incontinent of bladder.</p> <p>Review of the Physician's Order dated March 3, 2011, revealed, "Foley care q (every) shift & (and) prn (as needed) Foley catheter cont (continued) from hospital."</p> <p>Medical record review revealed no assessment to determine the medical justification for continued use of the indwelling catheter. Review of the resident's care plan dated January 20, 2011, revealed the care plan had not been revised to include the resident's use of the indwelling catheter, and interventions related to caring for the indwelling catheter.</p> <p>Interview with the MDS Coordinator on March 24, 2011, at 8:30 a.m., in the Coordinator's office</p>	F 315	<p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>All residents were reviewed by the Director of Nursing and the 7-3 Charge Nurse on 4/4/11. Resident(s) requiring a foley catheter was assessed using the "...Inwelling Catheter Evaluation" form by the 7-3 Charge Nurses on 4/4/2011.</p>	4/4/11
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F 315	<p>Continued From page 12</p> <p>confirmed the resident had not been assessed for medical justification for the use of the indwelling catheter, and the care plan had not been revised to reflect the use of the indwelling catheter.</p> <p>Resident #6 was admitted to the facility on June 29, 2009, with diagnoses including Paralysis, Ruptured Cerebral Aneurysm, Cerebrovascular Accident with Right Hemiparesis, and Insulin Dependent Diabetes Mellitus.</p> <p>Medical record review of the Admission Physician Order, dated June 29, 2009, revealed "... Foley Catheter..." Medical record review of the physician phone order dated November 19, 2010, revealed "...Bladder training x (times) 16 hours. Remove Foley 11-10-11 in AM..."</p> <p>Medical record review of the Assessment for Bowel and Bladder Training dated June 29, 2010, revealed "...present bladder: Foley...Evaluation: ..Unable to participate in B/B (Bowel/Bladder) training-Reason: sp (status post) CVA (Cerebrovascular Accident) with Right side paralysis..."</p> <p>Medical record review of the Progress Notes dated October 12, 2010, revealed "...Indwelling cath. (catheter) cont. (continued). trted (treated) for several U.T.I. (Urinary Tract Infections)...Not a candidate for training...signed by the Minimum Data Set Coordinator..."</p> <p>Interview, with the Director of Nursing (DON) on March 23, 2011, at 9:15 a.m., and March 24, 2011, at 2:35 p.m., in the DON's office, confirmed the facility did not perform an admission catheter assessment to determine appropriateness of</p>	F 315	<p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>In-service was conducted on 4/4/2011 by the Director of Nursing. "Urinary Incontinence/ Indwelling Catheter Evaluation" will be performed by the admitting nurse on all residents who are admitted or re-admitted with a foley catheter. The Physician's were informed by the Director of Nursing on 4/4/2011 of the need for a diagnosis/ medical justification for the use of a foley catheter. Nursing Staff will use the "Lippencott" book of "Standards of Nursing Practice" to determine appropriate use of foley catheter.</p>	<p><i>Who and where interviewed?</i></p> <p><i>4/4/11</i></p>
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F 315	<p>Continued From page 12</p> <p>confirmed the resident had not been assessed for medical justification for the use of the indwelling catheter, and the care plan had not been revised to reflect the use of the indwelling catheter.</p> <p>Resident #6 was admitted to the facility on June 29, 2009, with diagnoses including Paralysis, Ruptured Cerebral Aneurysm, Cerebrovascular Accident with Right Hemiparesis, and Insulin Dependent Diabetes Mellitus.</p> <p>Medical record review of the Admission Physician Order, dated June 29, 2009, revealed "...Foley Catheter..." Medical record review of the physician phone order dated November 19, 2010, revealed "...Bladder training x (times) 16 hours. Remove Foley 11-10-11 in AM..."</p> <p>Medical record review of the Assessment for Bowel and Bladder Training dated June 29, 2010, revealed "...present bladder: Foley...Evaluation: ..Unable to participate in B/B (Bowel/Bladder) training-Reason: sp (status post) CVA (Cerebrovascular Accident) with Right side paralysis..."</p> <p>Medical record review of the Progress Notes dated October 12, 2010, revealed "...Indwelling cath. (catheter) cont. (continued). trted (treated) for several U.T.I. (Urinary Tract Infections)...Not a candidate for training...signed by the Minimum Data Set Coordinator..."</p> <p>Interview, with the Director of Nursing (DON) on March 23, 2011, at 9:15 a.m., and March 24, 2011, at 2:35 p.m., in the DON's office, confirmed the facility did not perform an admission catheter assessment to determine appropriateness of</p>	F 315	<p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>The Director of Nursing or the MDS Coordinator will review all new admissions or re-admissions with a foley catheter for appropriate forms and diagnosis.</p> <p>This will be monitored by the QA Committee for 6 months or as deemed necessary by the committee.</p> <p>QA Committee: Director of Nursing; MDS Coordinator; Dietary Supervisor; Social Services Director; Administrator; Pharmacist; Medical Director; Floor Nurse and C.N.A.</p>	4/4/11
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F 315	Continued From page 13 need. Further interview confirmed there was no ongoing assessment to determine appropriateness of need for the catheter. Further interview confirmed the facility had no policy for catheter use.	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on medical record review, policy review, and staff interview, the facility failed to provide the tube feeding formula as ordered by the physician, failed to clarify the physician order for the tube feeding, failed to notify the physician the tube feed formula ordered was not available, and administered a formula not ordered by the physician for one resident (#8) of fifteen residents reviewed. The findings included: Resident #8 was admitted to the facility on June 22, 2009, with diagnoses including Chronic Obstructive Pulmonary Disease, Arteriosclerotic Cardiovascular Disease, Atrial Fibrillation, Percutaneous Endoscopic Gastrostomy, and Chronic Pain.	F 322	F 322 1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE? Resident #8: The physician was contacted on 3/24/11 by the Director of Nursing to receive clarification of the order in question. The order was clarified and written correctly on the MAR. The Registered Dietitian was contracted on 3/24/11 by the Dietary Supervisor for clarification of her recommendations. Recommendations were received on 3/25/11, the Physician was contacted by the Director of Nursing and recommendations were put into place on 3/25/11.	4/30/11

APR 08 2011

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F 322	<p>Continued From page 14</p> <p>Medical record review of the Minimum Data Set (MDS) dated January 12, 2011, revealed the resident's Brief Interview for Mental Status (cognitive status) was 1 out of fifteen (fifteen being highest cognitive status); fed by tube feeding greater than 501 cubic centimeters per day; and received greater than fifty-one percent of calories by the tube feeding.</p> <p>Medical record review of the Recapitulation physician orders dated December 2010, through March 2011, revealed the following tube feeding orders originated at admission: A.) "...PEG Tube: 1 Cal (calorie) HN (High Nitrogen) 237 ml (milliliters) at bedtime follow with 250 ml water..." B.) "...Peg Tube: 2 Cal HN 237 ml follow with 237 ml (of) water..."</p> <p>Medical record review of the December 2010, through March 2011, Recapitulation physician orders, originating on March 31, 2010, revealed "...feeding tube 118 ml at 9 am and 3 p.m. flush with 100 ml water after each..."</p> <p>Medical record review of the Weight Record revealed the resident's weight was stable at 119-128 pounds from May 2010 through February 2011.</p> <p>Review of the facility policy for "Physician Notification of Change in Resident Status Policy" revealed the "...Purpose: To establish guidelines to inform the nurse when a physician must be notified...Procedure: The physician will be notified of the following unless otherwise ordered: 2. A physician will be notified when a doctor's order needs clarification...14. Any other circumstances as indicated by resident's</p>	F 322	<p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>All residents who require tube feedings were reviewed by the Director of Nursing on 3/30/11 for clear orders.</p> <p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>In-service was conducted on 4/4/2011 by the Director of Nursing. The Policy "Physician notification of Change" was reviewed with emphasis on notifying the physician when orders need clarifying. The DON will review policy with nurses on LOA upon their return to work, also with nurses who missed the inservice by 4/30/11.</p>	<p>4/30/11</p> <p>4/30/11</p>
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APR 08 2011

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/24/2011
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NAME OF PROVIDER OR SUPPLIER BLED SOE COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367
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F 322	<p>Continued From page 15 behavior, condition or status warrants..."</p> <p>Interview, with the Director of Nursing (DON) on March 24, 2011, at 10:12 a.m., in the DON's office and medicine room, revealed the DON thought the resident was provided 1.0 Cal Glucerna for the 1 Cal HN 237 ml at bedtime due to the resident being a diabetic. The DON confirmed 1.0 Cal Glucerna was provided to the resident at bedtime.</p> <p>Interview, by phone, with Licensed Practical Nurse (LPN) #5, on March 24, 2011, at 10:15 a.m., confirmed the LPN administered 1.0 Cal Glucerna at bedtime. Further interview revealed the LPN "...gives whatever the MAR says..."</p> <p>Further interview with LPN #5, at 12:40 p.m., at the nursing station, on March 24, 2011, confirmed the LPN administered 1.0 Cal Glucerna at bedtime.</p> <p>Interview, by phone, with LPN #4, on March 24, 2011, at 10:41 a.m., confirmed the LPN administered 2 Cal HN at bedtime.</p> <p>Interview, by phone, with LPN #1 on March 24, 2011, at 12:50 p.m., confirmed the LPN administered 1.0 Cal Glucerna at bedtime. Further interview revealed the LPN was aware there was no product such as 1 Cal HN from working at the hospital. Further interview confirmed LPN #1 had not notified the physician there was no product called 1 Cal HN. Further interview revealed "...a day shift nurse told me to use Glucerna..."</p> <p>Interview, by phone, with LPN #6, on March 24, 2011, at 12:53 p.m., revealed the LPN administered 1.0 Cal Glucerna at bedtime</p>	F 322	<p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>MARs will be checked by 2 charge nurses monthly and as needed with new orders for clarification. New orders will be checked by at least 1 nurse on each shift for correctness and clarification as evidenced by the nurse's initials on the "yellow" copy of the order sheet. The DON will check for initials as well as correct and clear documentation. This will be monitored by the QA Committee for 6 months or as deemed necessary by the committee.</p> <p>QA Committee: Director of Nursing; MDS Coordinator; Dietary Supervisor; Social Services Director; Administrator; Pharmacist; Medical Director; Floor Nurse and C.N.A.</p>	<p><i>- see MARs? which 2 eng nurse?</i></p> <p><i>- how know which nurse?</i></p> <p><i>4/30/11</i></p> <p><i>how often will DON check?</i></p>
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APR 08 2011

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F 322	<p>Continued From page 16</p> <p>because the "...can says 1.0 Cal..." Further interview confirmed the LPN did not notify the physician that 1 Cal HN was not available.</p> <p>Interview, by phone, with the facility Registered Dietitian (RD) on March 24, 2011, at 1:32 p.m., confirmed the RD thought all formula provided was 2 Cal HN. When read the 1 Cal HN at bedtime order the RD revealed the RD was not aware of such an order and there was no such product as 1 Cal HN. Further interview revealed the RD was not aware the nurses were administering 1.0 Cal Glucerna at bedtime.</p> <p>Interview, with LPN #3, on March 24, 2011, at 10:50 a.m., in the hall by the resident's room, revealed this LPN administered 2 Cal HN at 10:00 a.m. When read the 118 ml order and asked how did the LPN know what formula to administer the LPN revealed "...because the 2 Cal HN 237 ml order is written above the 118 ml order..."</p> <p>Interview with the facility Material Director, on March 24, 2011, at 1:40 p.m., in the Administrative Office, revealed "...would order what nursing tells me based on physician order...would notify any nurse that product not available..."</p> <p>Interview, in the Chapel, with the DON on March 24, 2011, at 12:57 p.m., confirmed the DON was not aware there was no such product as 1 Cal HN. Further interview confirmed the 2 Cal HN order did not specify the frequency of the administration. Further interview confirmed the order of 118 ml at 9:00 a.m. and 3:00 p.m. did not specify a formula to be administered. Further interview confirmed the facility failed to notify the physician that there was no such product as 1 Cal</p>	F 322		
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F 322	Continued From page 17 HN. Further interview confirmed the facility failed to clarify all the tube feeding orders. Further interview confirmed the facility was administering 1.0 Cal Glucerna without a physician order.	F 322			
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, observation, and interview, the facility failed to ensure a safe environment by securing chemicals and sharps from one resident (#15); failed to secure sharps from the general population, and ensure the safety device was in place for one resident (#1) of fifteen residents reviewed. The findings included: Resident # 15 was admitted to the facility on January 4, 2009, with diagnoses including Hypertension, Dementia, and Hard of Hearing. Medical record review of the Minimum Data Set (MDS) dated October 15, 2010, revealed a BIMS (Brief Interview for Mental Status) score of six out of fifteen (with fifteen being the highest cognitive status.) Continued review revealed the resident was independent with transfers, ambulation, dressing, and personal hygiene.	F 323	F 323 1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE? Resident #15: All personal hygiene products were properly stored out of residents view. Used razors were placed in sharps container by the C.N.A.'s on duty for B Hall on 3/22/11. Open razors and other items were placed in the secure cabinet between showers by the C.N.A.s beginning on 3/22/11. Resident #1: The bed alarm was attach to the resident properly by the Director of Nursing on 3/22/11.	4/4/11	

APR 08 2011

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F 323	<p>Continued From page 18</p> <p>Observation during the initial tour on March 22, 2011, at 11:00 a.m., revealed the following items on the resident's over bed table: Baby Oil, 20 ounces, ¾ full; Mouthwash containing 26.9 % alcohol, 50 ounces, ¾ full; Petroleum jelly, 3.75 ounces, minimal contents remaining.</p> <p>Continued observation at this time in the resident's bathroom revealed two disposable razors on the back of the resident's sink.</p> <p>Observation and interview with LPN #1, on March 22, 2011, at 11:15 a.m., confirmed the razors should not have been left on the back of the sink.</p> <p>Observation and interview with the Director of Nursing (DON) on March 22, 2011, at 11:30 a.m., in the resident's room confirmed the items found on the resident's over bed table belonged to the resident, and had not been stored in a secure manner.</p> <p>Continued observation and interview with the DON confirmed the razors should have been placed in a sharps container.</p> <p>Observation of the resident-accessible, B-hall shower room on March 23, 2011, at 9:15 a.m., revealed an open package of disposable razors stored on the linen cart.</p> <p>Observation and interview with the DON on March 23, 2011, at 11:30 a.m., in the B-hall shower room confirmed the razors had not been stored in a safe, secure manner.</p> <p>Resident #1 was admitted to the facility on July 7, 2010, with diagnoses including Alzheimer's Dementia, Chronic Obstructive Pulmonary</p>	F 323	<p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>A visual inspection of all resident rooms and shower rooms was conducted by the Director of Nursing, the Administrator and various members of the Nursing Staff on 3/22/11, 3/23/11 and 3/24/11 to ensure proper placement of sharps and "chemicals"</p> <p>Each resident who required a personal alarm was inspected by the Director of Nursing on 3/22/11 for proper placement.</p> <p><i>How do direct care staff know what type of safety device is to be on a resident?</i></p>	4/4/11
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APR 08 2011

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F 323	<p>Continued From page 18</p> <p>Observation during the initial tour on March 22, 2011, at 11:00 a.m., revealed the following items on the resident's over bed table: Baby Oil, 20 ounces, ¾ full; Mouthwash containing 26.9 % alcohol, 50 ounces, ¾ full; Petroleum jelly, 3.75 ounces, minimal contents remaining.</p> <p>Continued observation at this time in the resident's bathroom revealed two disposable razors on the back of the resident's sink.</p> <p>Observation and interview with LPN #1, on March 22, 2011, at 11:15 a.m., confirmed the razors should not have been left on the back of the sink.</p> <p>Observation and interview with the Director of Nursing (DON) on March 22, 2011, at 11:30 a.m., in the resident's room confirmed the items found on the resident's over bed table belonged to the resident, and had not been stored in a secure manner.</p> <p>Continued observation and interview with the DON confirmed the razors should have been placed in a sharps container.</p> <p>Observation of the resident-accessible, B-hall shower room on March 23, 2011, at 9:15 a.m., revealed an open package of disposable razors stored on the linen cart.</p> <p>Observation and interview with the DON on March 23, 2011, at 11:30 a.m., in the B-hall shower room confirmed the razors had not been stored in a safe, secure manner.</p> <p>Resident #1 was admitted to the facility on July 7, 2010, with diagnoses including Alzheimer's Dementia, Chronic Obstructive Pulmonary</p>	F 323	<p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>Inservice was conducted on 4/4/11 by the Director of Nursing. Charge Nurses on each shift will monitor residents for proper alarm placement during medication pass times. (This will be on-going). Charge Nurses will conduct visual inspections of the resident's rooms during medication passes to ensure proper placement of personal hygiene and "chemicals". (This will be on-going).</p>	<p>4/4/11</p> <p><i>for what & who?</i></p> <p><i>how know what devices to be on?</i></p> <p><i>Is it on MAR?</i></p>
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F 323	Continued From page 19 Disease, History of Falls, and Tremors. Review of the Minimum Data Set (MDS) dated January 20, 2011, revealed the resident had significant cognitive impairment, required extensive assistance for transfers, was non-ambulatory, and incontinent of bladder. Review of the facility's documentation revealed the resident was a high risk for falls, and had care plan interventions dated January 20, 2011, for the use of a bed/chair alarm at all times. Review of the Physician's Orders dated March 20, 2011, revealed, "Bed Alarm when in bed." Observation during the initial tour on March 22, 2011, at 10:45 a.m., and March 23, 2011, at 10:30 a.m., revealed the resident in bed, side rails up, and a tab alarm on the right side rail, unattached to the resident. Observation and interview with the Director of Nursing on March 23, 2011, at 10:30 a.m., in the resident's room confirmed the tab alarm was not attached to the resident.	F 323	4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? Inservice by the Director of Nursing on 4/4/2011. Monitored daily by the Charge Nurses on each shift. Random monitoring by the DON and/or the MDS Coordinator. Will be monitored by the QA Committee for 6 months or as deemed necessary by the committee. QA Committee: Director of Nursing; MDS Coordinator; Dietary Supervisor; Social Services Director; Administrator; Pharmacist; Medical Director; Floor Nurse and C.N.A.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain 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	F 425		

for what & who monitored? how 4/4/11 walking rounds

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F 425	<p>Continued From page 20 the needs of each resident.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility's consultant pharmacist report, and interview, the facility failed to ensure the pharmacist provided the timely identification and removal (from current medication supply) of expired medications for disposition.</p> <p>The findings included:</p> <p>Review of the "Consultant Pharmacist Monthly Report for December 2010, January 2011, and February 2011, revealed, "...Medication Storage-Medication rooms did not contain expired or discontinued medications..."</p> <p>Observation of the medication room on March 23, 2011, at 9:00 a.m., revealed the following expired medications in the Emergency Medications Box: Digoxin Injection-500mcg/2ml vial (500 micrograms per 2 milliliters); one vial with a manufacturer's expiration date of March 2007 on the label of the vial; Atropine Sulfate Injection-1mg (milligram); two vials with a manufacturer's expiration date of March 1, 2007 on the label of the vials; Atropine Sulfate Injection-1mg (milligram); one vial with a manufacturer's expiration date of July</p>	F 425	<p>F 425</p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>All expired medications were removed from the medication room and disposed of on March 23, 2011.</p> <p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>The medication room was checked by the Director of Nursing and the 7-3 Charge Nurse on 3/23/11 to ensure no expired medications remained.</p>	<p>4/4/11</p> <p>4/4/11</p>
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F 425	<p>Continued From page 21</p> <p>1, 2007 on the label of the vial; 50% (percent) Dextrose Injection-25gms (grams); one vial with a manufacturer's expiration date of August 1, 2007 on the label of the vial; Bacteriostatic 0.9% Sodium Chloride Injection-30ml Multiple-Dose vial; two vials with a manufacturer's expiration date of September 1, 2007 on the label of the vials; Epinephrine Injection-1mg/ml vial (one milligram per milliter); one vial with a manufacturer's expiration date of April 1, 2008 on the label of the vial; Digoxin Injection-500mcg/2ml vial (500 micrograms per 2 milliliters); one vial with a manufacturer's expiration date of December 2008 on the label vial.</p> <p>Continued observation in a cabinet attached to the wall inside the medication room revealed multiple cartons of medications with the manufacturer's expiration date of January 2011 on the cartons as follows: Five cartons of Ipratropium Bromide 0.5mg and Albuterol Sulfate 3mg Inhalation Solution, for a total of 165 expired unit-dose vials; Four carton of Ipratropium Bromide 0.5mg/2.5ml Inhalation Solution, for a total of 240 expired unit-dose vials</p> <p>Interview with the consultant pharmacist via telephone from the facility conference room on March 23, 2011, at 1:00 p.m., confirmed the consultant pharmacist's monthly reports for December 2010, and Janaury and February 2011 were inaccurate. Further interview confirmed the facility no longer used the Emergency Medications Box as emergency situations are handled in the hospital emergency room (located in the same building beside the nursing home).</p>	F 425	<p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>The Consultant Pharmacist will make visual inspections of the medication room at least monthly. Inservice was conducted 4/4/2011 by the Director of Nursing. The 3-11 Charge Nurse will be responsible for inspecting the medication room weekly to ensure no medications are expired. The Charge Nurse will document her findings. the Director of Nursing or the MDS Coordinator will made weekly checks of documentation. The Emergency Box was discussed with the Medical Director by the Director of Nursing and it has been decided not to have the current Emergency box in place due to the close proxcemity of Emergency Room (the hospital is attached to the nursing home)</p>	<p>4/4/11 - for who & for what?</p>
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F 425	<p>Continued From page 21</p> <p>1, 2007 on the label of the vial; 50% (percent) Dextrose Injection-25gms (grams); one vial with a manufacturer's expiration date of August 1, 2007 on the label of the vial; Bacteriostatic 0.9% Sodium Chloride Injection-30ml Multiple-Dose vial; two vials with a manufacturer's expiration date of September 1, 2007 on the label of the vials; Epinephrine Injection-1mg/ml vial (one milligram per milliliter); one vial with a manufacturer's expiration date of April 1, 2008 on the label of the vial; Digoxin Injection-500mcg/2ml vial (500 micrograms per 2 milliliters); one vial with a manufacturer's expiration date of December 2008 on the label vial.</p> <p>Continued observation in a cabinet attached to the wall inside the medication room revealed multiple cartons of medications with the manufacturer's expiration date of January 2011 on the cartons as follows: Five cartons of Ipratropium Bromide 0.5mg and Albuterol Sulfate 3mg Inhalation Solution, for a total of 165 expired unit-dose vials; Four carton of Ipratropium Bromide 0.5mg/2.5ml Inhalation Solution, for a total of 240 expired unit-dose vials</p> <p>Interview with the consultant pharmacist via telephone from the facility conference room on March 23, 2011, at 1:00 p.m., confirmed the consultant pharmacist's monthly reports for December 2010, and Janaury and February 2011 were inaccurate. Further interview confirmed the facility no longer used the Emergency Medications Box as emergency situations are handled in the hospital emergency room (located in the same building beside the nursing home).</p>	F 425	<p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>The Director of Nursing or the MDS Coordinator will made weekly checks of documentation. This will be monitored by the QA Committee for 6 months or as deemed necessary by the Committee.</p> <p>QA Committee: Director of Nursing; MDS Coordinator; Dietary Supervisor; Social Services Director; Administrator; Pharmacist; Medical Director; Floor Nurse and C.N.A.</p>	<p><i>for how long</i></p> <p><i>4/4/11</i></p>
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APR 08 2011

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/24/2011
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NAME OF PROVIDER OR SUPPLIER BLED SOE COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 22 Continued interview confirmed the consultant pharmacist failed to ensure the timely identification and removal of expired medications from the facility's current medication supply in the medication room.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 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.	F 431	F 431 1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE? All expired medications were removed from the medication room and disposed of on March 23, 2011. 2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE? The medication room was checked by the Director of Nursing and the 7-3 Charge Nurse on 3/23/11 to ensure no expired medications remained.	4/4/11 4/4/11

APR 08 2011

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F 431	<p>Continued From page 23</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the disposal of expired medications from the medication room.</p> <p>The findings included:</p> <p>Observation on March 23, 2011, at 9:00 a.m., of the medication room, revealed the following expired medications in the Emergency Medications Box: Digoxin Injection-500mcg/2ml vial (500 micrograms per 2 milliliters); one vial with a manufacturer's expiration date of March 2007 on the label of the vial; Atropine Sulfate Injection-1mg (milligram); two vials with a manufacturer's expiration date of March 1, 2007 on the label of the vials; Atropine Sulfate Injection-1mg (milligram); one vial with a manufacturer's expiration date of July 1, 2007 on the label of the vial; 50% (percent) Dextrose Injection-25gms (grams); one vial with a manufacturer's expiration date of August 1, 2007 on the label of the vial; Bacteriostatic 0.9% Sodium Chloride Injection-30ml Multiple-Dose vial; two vials with a manufacturer's expiration date of September 1, 2007 on the label of the vials; Epinephrine Injection-1mg/ml vial (one milligram per milliliter); one vial with a manufacturer's expiration date of April 1, 2008 on the label of the vial; Digoxin Injection-500mcg/2ml vial (500 micrograms per 2 milliliters); one vial with a manufacturer's expiration date of December 2008</p>	F 431	<p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>The Consultant Pharmacist will make visual inspections of the medication room at least monthly. Inservice was conducted 4/4/2011 by the Director of Nursing. The 3-11 Charge Nurse will be responsible for inspecting the medication room weekly to ensure no medications are expired. The Charge Nurse will document her findings. the Director of Nursing or the MDS Coordinator will made weekly checks of documentation. The Emergency Box was discussed with the Medical Director by the Director of Nursing and it has been decided not to have the current Emergency box in place due to the close proxcemity of Emergency Room (the hospital is attached to the nursing</p>	<p><i>- for what wing 4/4/11</i></p>
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F 431	Continued From page 24 on the label vial; Continued observation in a cabinet attached to the wall inside the medication room revealed multiple cartons of medications with the manufacturer's expiration date of January 2011 on the cartons as follows: Five cartons of Ipratropium Bromide 0.5mg and Albuterol Sulfate 3mg Inhalation Solution, for a total of 165 expired unit-dose vials; Four carton of Ipratropium Bromide 0.5mg/2.5ml Inhalation Solution, for a total of 240 expired unit-dose vials. Interview with Licensed Practical Nurse (LPN) #2 in medication room on March 23, 2011, at 9:30 a.m., confirmed the facility failed to dispose of the expired medications from the medication room.	F 431	4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? The Director of Nursing or the MDS Coordinator will made weekly checks of documentation. This will be monitored by the QA Committee for 6 months or as deemed necessary by the Committee. QA Committee: Director of Nursing; MDS Coordinator; Dietary Supervisor; Social Services Director; Administrator; Pharmacist; Medical Director; Floor Nurse and C.N.A. F 502	For how long? 4/4/11	
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of laboratory data, review of treatment sheets, and interview, the facility failed to obtain a Vitamin D level as ordered by the physician for one resident (#8) of fifteen residents reviewed. The findings included: Resident #8 was admitted to the facility on June 22, 2009, with diagnoses including Chronic	F 502	1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE? Resident #8: Lab requisition was sent to the laboratory for level to be drawn on 3/24/11.	3/31/11	

APR 08 2011

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F 502	Continued From page 25 Obstructive Pulmonary Disease, Arteriosclerotic Cardiovascular Disease, Atrial Fibrillation and Chronic Pain. Medical record review of a physician phone order dated January 6, 2011, revealed "...2) Vit. (Vitamin) D level in early March..." Medical record review of the laboratory data revealed no documentation of a Vitamin D level for March 2011. Medical record review of the February and March 2011, treatment sheets revealed no documentation to obtain a Vitamin D level in March 2011. Interview, with the Director of Nursing on March 24, 2011, at 10:37 a.m., in the DON's office, confirmed the facility failed to obtain the Vitamin D level as ordered by the physician. Further interview revealed the facility wrote the order on the treatment sheet for January 2011, and were to carry it forward on the February and March 2011, treatment sheets until the order was obtained.	F 502	2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE? January, February and March treatment sheets were reviewed for all residents by the Director of Nursing 3/29,30&31/2011 for appropriate documentation and "carry-over".	3/31/11
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	F 514	3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? Treatment sheets will be double checked by the 11-7 charge nurse after being completed by the Director of Nursing and prior to placing in the treatment book for the next month. The nurse will initial at the top of the sheet to indicate that the sheet has been checked.	3/31/11

APR 08 2011

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F 502	Continued From page 25 Obstructive Pulmonary Disease, Arteriosclerotic Cardiovascular Disease, Atrial Fibrillation and Chronic Pain. Medical record review of a physician phone order dated January 6, 2011, revealed "...2) Vit. (Vitamin) D level in early March..." Medical record review of the laboratory data revealed no documentation of a Vitamin D level for March 2011. Medical record review of the February and March 2011, treatment sheets revealed no documentation to obtain a Vitamin D level in March 2011. Interview, with the Director of Nursing on March 24, 2011, at 10:37 a.m., in the DON's office, confirmed the facility failed to obtain the Vitamin D level as ordered by the physician. Further interview revealed the facility wrote the order on the treatment sheet for January 2011, and were to carry it forward on the February and March 2011, treatment sheets until the order was obtained.	F 502	4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR. The Director of Nursing will check the treatment sheets weekly for accurate orders. Any new orders will be checked by at least one nurse from each shift and indicate correctness by initials on a copy of the order. This will be monitored by the QA committee for 6 months or until deemed by the committee.		
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	F 514	QA Committee: Director of Nursing; MDS Coordinator; Dietary Supervisor; Social Services Director; Administrator; Pharmacist; Medical Director; Floor Nurse and C.N.A.	3/31/11	

how do new orders get to the tx sheets?

890 how long

APR 08 2011

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F 514	<p>Continued From page 26 services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, pharmacy consultant document review, and interview, the facility failed to maintain an accurate medical record for one resident (#5) of fifteen residents reviewed.</p> <p>The findings included:</p> <p>Resident #5 was admitted to the facility on May 14, 2010, with diagnoses including Osteoarthritis, Congestive Heart Failure and Chronic Pain Syndrome.</p> <p>Medical record review of the Minimum Data Set dated February 24, 2011, revealed the resident received scheduled and as needed pain medication. Further review revealed the pain was experienced frequently with an intensity of eight out of ten (ten being the worst pain imaginable) and a verbal description of "...very severe, horrible..."</p> <p>Medical record review revealed an "Initial Pain Assessment Tool" dated May 14, 2010, revealed "...Location (of the pain): (no) c/o (complaints) of pain at this time. Hx: neck, bil (bilateral) leg, back, bil shoulder...Intensity: (0-10 scale) not present, worse pain gets 8...What relieves pain: "pain pill I get 3 times a day"...Plan: Hydrocodone-APAP 5/500 one po TID (by mouth three times daily)..."</p>	F 514	<p>F 514</p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>Resident #5: Medications were reviewed by the Physician on 3/30/11 and PRN pain medications were changed to routine.</p> <p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>MARs of all residents were reviewed and discussed by the Director of Nursing and 7-3 charge nurse on 4/4/11.</p>	<p>4/4/11</p> <p>4/4/11</p>
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F 514	<p>Continued From page 27</p> <p>Medical record review of the physician order initiated on May 14, 2010, current to the present date, revealed "...Hydrocodone (pain medication)...5/500 take one tablet every 8 hours as needed (PRN) for pain..."</p> <p>Medical record review of the Medication Administration Record (MAR) revealed the following: December 2010: twenty-nine administrations of the medication. January 2011: twenty-nine administrations of the medication. February 2011: thirty-five administrations of the medication. March 2011: thirty-nine administrations of the medication.</p> <p>Medical record review of the back of the MAR revealed "...Instructions...d. PRN Med: Reason given and results should be noted on Nurse's Medication Notes..." Further review revealed Nurse's Medication Notes including date/hour, medication/dosage, reason, result/response, and hour/initial. Further review revealed the following:</p> <p>December 2010: seventeen of the twenty-nine administrations lacked documentation under the Nurse's Medication Notes. Further review revealed on December 10, 2010, Nurse's Medication Notes documented PRN Hydrocodone was administered at 9:00 p.m. but the MAR lacked documentation of this administration.</p> <p>January 2011: eight of the twenty-nine administrations lacked documentation under the Nurse's Medication Notes. Further review of the Nurse's Medication Notes revealed on January 3, 2011 at 8:00 a.m., and January 4, 2011, no time</p>	F 514	<p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>Inservice was conducted by the Director of Nursing on 4/4/11. PRN Documentation policy was inserviced at that time. Wong-Baker Pain Scale was put into effect beginning 4/4/11 for all PRN pain medications to identify the intensity of the pain as well as the effectiveness of the pain medication.</p>	<p><i>for who?</i></p> <p><i>4/4/11</i></p>
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APR 08 2011

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F 514	<p>Continued From page 28</p> <p>was documented, PRN Hydrocodone was administered but the MAR lacked documentation of the administration.</p> <p>February 2011: two of the thirty-five administrations lacked documentation under the Nurse's Medication Notes.</p> <p>March 1-23, 2011: nine of the thirty-nine administrations lacked documentation under the Nurse's Medication Notes. Further review of the Nurse's Medication Notes revealed on March 3 and 4, 2011, at 8:00 p.m., PRN Hydrocodone was administered but the MAR lacked documentation of the administration.</p> <p>Review of the Pharmacy Consultant Monthly Report, dated December 2010, and January and February 2011, revealed "...Charting and Documentation: PRN medication were always administered with proper documentation of reason, effectiveness, or reason of administration.</p> <p>Interview, with consultant pharmacist, via telephone, from the facility conference room on March 23, 2011, at 1:00 p.m., confirmed the consultant pharmacist's monthly reports for December 2010, and January and February 2011 were inaccurate.</p> <p>Interview, with the Administrator and the Director of Nursing (DON) in the Administrative Office, on March 23, 2011, at 3:14 p.m., revealed the PRN medication administration was to be documented at the time of the administration and included the nurse's initials on the front of the MAR and the date, time, medication, reason for administration and the result on the back of the MAR. Further</p>	F 514	<p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>MARs will be monitored weekly by the Director of Nursing or the MDS Coordinator for complete documentation of PRN medications including intensity. This will be monitored by the QA Committee for 6 months or as deemed necessary by the committee.</p> <p>QA Committee: Director of Nursing; MDS Coordinator; Dietary Supervisor; Social Services Director; Administrator; Pharmacist; Medical Director; Floor Nurse and C.N.A.</p>	<p><i>Frequency?</i></p> <p>4/4/11</p>
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F 514	<p>Continued From page 29</p> <p>interview confirmed the front of the MAR did not correspond with the Nurse's Note on the back of the MAR to validate the administration of the PRN Hydrocodone and the medical record was not accurate.</p> <p>Interview, on March 24, 2011, at 7:54 a.m. with the DON in the Chapel confirmed the facility did not have a policy addressing PRN medication and trained the staff verbally on the policies.</p>	F 514		
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APR 08 2011