

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

45th 12/25/11

PRINTED: 11/15/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445404	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/10/2011
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NAME OF PROVIDER OR SUPPLIER BLOUNT MEMORIAL TRANS CARE CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804
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F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to revise care plans for one resident (#525) for intravenous antibiotics, Urinary Tract Infection (UTI), and Contact Isolation; for two residents (#270, #285) for intravenous fluids, and for one resident (#165) for the use of an anticoagulant (blood thinner), of sixteen residents reviewed.</p> <p>The findings included:</p>	F 279	<p>The corrective action taken to assist the resident affected by this deficient practice was as followed: First, on Resident #525 the Interim Plan of Care was not updated to include the treatment of the UTI with Cefazidime 1 Gm (gram) IV (intravenous) BID (2 times a day) x 10 days UTI (Urinary Tract Infection) with contact isolation. A new process change was made to incorporate the Kardex and Plan of Care together so that the information is captured in one area for all disciplines to observe. The Kardex (s) will no longer be used and the Kardex notebook will be converted to the Plan of Care Notebook. This new process will be implemented with all staff during the ICC Unit Meeting on Tuesday November 29, 2011. Secondly on resident #270, the order 1/2 NS (Normal Saline) @ 75cc/hr (Hour) x 2 liters was not updated to the Interim Plan of Care and did not reveal the problem or approaches to address the IV fluids. Again, a new process change was made to incorporate the Kardex and Plan of Care together so that the information is captured in one area for all disciplines to observe. The Kardex (s) will no longer be used and the Kardex notebook will be converted to the Plan of Care Notebook. The process includes the IV fluids with a space to add the reasoning for the IV fluids. This new process will be implemented with all staff during our unit meeting on 11/29/11. Our due date for full implementation of this process will be 12/12/11 after everyone has been educated and reviewed the process. Thirdly, on resident #285, IV Zosyn (antibiotic) for possible pneumonia and NS at 75ml/hr x 1 liter were not revealed on the Interim Plan of Care. Fourth, on resident #165 had an order for Coumadin (anticoagulant/blood thinner) 5mg (milligram) 1 tablet by mouth daily. The Interim Plan of Care did not include the risk of anticoagulation use. Although the information for signs and symptoms of abnormal bleeding related to anticoagulation use are noted on the Interim Plan of Care, the nurse failed to mark this area to be monitored. In addition to following the new TCC Plan of Care Process, this information will be reviewed as well at the Unit Meeting on Tuesday November 29, 2011.</p>	12/12/11
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Corie M. Codieux</i>	TITLE Administrator	(X6) DATE 11/23/11
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ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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F 279	Continued From page 1 Resident #525 was admitted to the facility on October 28, 2011, with diagnoses including End Stage Renal Disease, Hypertension, and Urinary Tract Infection. Medical record review of the physician's order dated November 2, 2011, revealed "...Ceftazidime 1 Gm (gram) IV (intravenous) BID (2 times a day) X 10 days UTI (Urinary Tract Infection)..." Medical record review of the resident's Interim Care Plan revealed no problems or approaches to address the IV antibiotics, the UTI, or contact isolation. Observation on November 10, 2011, at 10:15 a.m., of the resident's room revealed a sign stating to use contact isolation precautions. Interview on November 10, 2011, at 11:00 a.m., with the Registered Nurse/Education/Quality/Infection Control confirmed the resident's Interim Care Plan was not revised to include the treatment of the UTI with contact isolation precautions. Resident #270 was admitted to the facility on June 2, 2011, with diagnoses including Ulcerative Colitis, Dehydration, Gastrointestinal Bleed, History of Brain and Spinal Tumor, and Thyroid Cancer. Medical record review of the physician order dated June 3, 2011, "... 1/2 NS (Normal Saline) @ 75cc hr (hour) X 2 liters..."	F 279	Other patients/residents with the potential to be affected by this deficient practice are any and all patients with orders for additional treatment will be added to the care plan when orders are processed. Measures to be put into place to ensure deficient practice does not reoccur are as follows: Ongoing observations are now being conducted by the Nursing Leadership staff, Quality Nurse Educator and Charge Nurses. Monitoring has been conducted on 11/10/11 by the PCC's, ADON, Quality Control Nurse and DON to ensure there are no other like situations with this deficient practice. These ongoing observations will be random and unannounced to staff - (to include all Interim Plan of Care & Comprehensive Plan of Care). In addition, to ensure this deficient practice does not reoccur our facility has made a Plan of Care Process change in that multiple items were added to the Interim Plan of Care to include Diagnosis for infections with route of administration of antibiotics along with intravenous fluids with rate. Details to other needed items that are not listed in the deficient practice were also added to the Plan of Care for improvement of patient care. Listed below are the new process changes for the TCC Plan of Care: 1. The Kardex and CNA Kardex were incorporated into the TCC Interim Plan of Care. This Plan of Care is used until the 14 day MDS Plan of Care is completed. 2. The TCC Interim Plan of Care will be used by all disciplines for report. Do not remove the Plan of Care from the Notebook unless you are taking orders off that need to be transferred to the Plan of Care or doing a Care Planning session. 3. Once the 14 day MDS Plan of Care is completed, the Ward Clerk will transfer up to date information from the Interim Plan of Care to the 14 day MDS Plan of Care. 4. The Interim Plan of Care will be filed in the chart under the care plan tab. 5. The 14 day MDS Plan of Care will be kept in the Plan of Care Notebook. 6. After completing the care planning sessions, the Plan of Care will be placed back in the Plan of Care Notebook or in the "Care Plans Only" basket.	

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F 279	<p>Continued From page 2</p> <p>Medical record review of the resident's Interim Care Plan revealed no problems or approaches to address the IV fluids.</p> <p>Interview on November 10, 2011, at 11:00 a.m., with the Director of Nursing confirmed the resident's Interim Care Plan was not revised to address the IV fluids.</p> <p>Resident #285 was admitted to the facility on October 2, 2011, with diagnoses including Hypopotassemia, Pneumonia, Dehydration, and Anemia.</p> <p>Medical record review of the hospital Emergency Room (ER) report dated October 7, 2011, revealed the resident was seen in the ER with a temperature of 100.8 and had been receiving IV Zosyn (antibiotic) for possible pneumonia at the facility. Continued review revealed the ER physician ordered "...NS at 75ml/hr x 1 liter..."</p> <p>Medical record review of the resident's Medication Administration Record revealed the resident received the IV fluids at the facility.</p> <p>Medical record review of the resident's Interim Care Plan revealed no problems or approaches for the IV fluids.</p> <p>Interview on November 10, 2011, at 11:00 a.m., in the conference room with the Registered Nurse/Education/Quality/Infection Control confirmed the resident's Interim Care Plan was not revised to address the IV fluids.</p>	F 279	<p>These corrective actions will be monitored by the Nursing Leadership staff, Quality Nurse Educator and Charge Nurses by observing and monitoring documentation on the Interim Plan of Care and Comprehensive Plan of Care to ensure that any missed information that the physician ordered was transcribed to the Plan of Care. Any incomplete documentation will result in further education and/or disciplinary action. Documentation on the Plan of Care is first taught in orientation and ongoing during employment. Plan of Care documentation will be reviewed/educated and monitored weekly by the Quality Nurse Educator and the Nursing Leadership staff. The ongoing Quality Measuring results on Plan of Care documentation will be discussed with the nursing staff at each monthly unit meeting and/or in nursing newsletter.</p>		

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F 279	Continued From page 3 Resident #165 was admitted to the facility on October 21, 2011, with diagnoses including history of Pulmonary Embolism, Chronic Obstructive Pulmonary Disease, Hypothyroidism, Diverticulosis, and anticoagulant use. Medical record review of the medication orders from admission dated October 21, 2011, revealed the resident was admitted on Coumadin (anticoagulant/blood thinner) 5 mg (milligram), 1 tablet by mouth daily. Review of the resident's interim care plan dated October 21, 2011, revealed the risks of anticoagulant use had not been included on the care plan. Interview with the Assistant Director of Nursing on November 9, 2011, in the music room at 4:30 p.m., confirmed the care plan had not been revised for the signs and symptoms of abnormal bleeding related to anticoagulant use.	F 279		
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.	F 431	The corrective action taken to assist the resident affected by this deficient practice was as followed: The facility failed to ensure that stock medications for resident use were within expiration date for one medication room (ground floor) revealed twenty-four, 5ml (milliliter), unit dose packages of liquid Guaifenesin (expectorant) with expiration dates of 10/11, stored in the medication room for resident use. First, to avoid this deficient practice, the Patient Care Coordinator will conduct weekly checks of the stock medications in the medication room. Secondly, the expiration dates will be checked in the Pyxis cabinet on a report menu and thirdly, the pharmacy will conduct a monthly check of the medication room to include checking stock medications for expiration.	11/18/11

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F 431	<p>Continued From page 4</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the stock medications for resident use were within the expiration date for one medication room (ground floor) of two medication rooms observed.</p> <p>The findings included: Observation with the Patient Care Coordinator of the ground floor medication storage room on 11/9/11 at 10:33 a.m., revealed twenty-four, 5 ml (milliliter), unit dose packages of liquid Guaifenesin (expectorant) with expiration dates of 10/11, stored in the medication room for resident use.</p> <p>Interview with the Patient Care Coordinator at this</p>	F 431	<p>Other patients/residents with the potential to be affected by this deficient practice are any and all patients with orders to receive medications.</p> <p>Measures to be put into place to ensure deficient practice does not reoccur are as follows Ongoing observations are now being conducted by the Nursing Leadership staff, Quality Nurse Educator and Charge Nurses. Monitoring has been conducted on 11/9/11 by the PCC's, ADON, Quality Control Nurse and DON to ensure there are no other like situations with this deficient practice. These ongoing observations will be conducted by the Patient Care Coordinators on a weekly basis to ensure no more expired medications are available for resident use. As of 11/18/11, the pharmacy has reduced the PAR level in the Pyxis cabinet to help reduce likelihood of expired medications. As accurate expiration dates are loaded into the Pyxis, this will be another check ensure that we have no expired medications. Also, the pharmacy will be conducting monthly observations of stock medications in the medication room and presenting the Director of Nursing with completed documentation on the observations.</p> <p>These corrective actions will be monitored by Nursing Leadership staff, Quality Nurse Educator and Charge Nurses by observing and monitoring for expired medications in the medication room to ensure that any expired medications are disposed of properly and pharmacy is notified. The Patient Care Coordinator will document weekly checks for expired medications and the Quality Nurse Educator will conduct random observations of the medications for expiration.</p> <p>The ongoing Quality Measuring results on medication expiration will be discussed at the monthly unit meetings and/or nursing newsletter, and at the Nursing Quality Improvement team monthly.</p>		

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F 431	Continued From page 5	F 431	The Pharmacy consultant will conduct monthly observation checks of medications and report findings to the pharmacy and Nursing Administration.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	The corrective action taken to assist the resident affected by this deficient practice was as followed: First, on resident #539 LPN#1 dropped a medication (Acyclovir) on the top of the medication cart, picked it up with bare fingers, placed it in the medication cup, and administered the medication to the resident. To correct this deficient practice, LPN#1 has been re-educated on 11/7/11 that this medication that was dropped on the top of the medication cart is contaminated. The medication is disposed of properly and replaced by a new medication. This was documented and put in LPN#1 education file. This will also be discussed in the TCC Unit Meeting on Tuesday November 29, 2011. Secondly on resident #523 in Contact Isolation for Clostridium Difficile and urine with Vancomycin Resistant Enterococcus the CNA#3 was observed entering the room with no gloves on to deliver a food tray and failed to adhere to facility policy of wearing gloves when entering the room. Confirmed policy immediately with CNA#3 to clarify her misunderstanding of the policy. This education was put into CNA#3's education file. Further clarification has been done & will be done immediately & at the TCC Unit Meeting on Tuesday November 29, 2011. Thirdly, on resident #525, CNA#1 contaminated her uniform and microphone on the two-way radio when touched with her gloved hands that were in contact with the patient in isolation. CNA#1 was re-educated on awareness of contamination of items in an isolation room. The TCC Isolation Policy was reviewed with CNA#1 and placed in her education file.	11/30/11

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F 441	<p>Continued From page 6 infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, observation, and interview, the facility failed to ensure medication administration was performed in a sanitary manner for one resident (#539) and failed to ensure isolation guidelines were followed for two (#523, #525) of two residents in isolation, of fifty six observed residents.</p> <p>The findings included:</p> <p>Observation of the medication administration on November 7, 2011, at 8:40 a.m., revealed Licensed Practical Nurse (LPN) #1 dropped a medication (Acyclovir) on the top of the medication cart, picked it up with bare fingers, placed it in the medication cup, and administered the medication to resident #539.</p> <p>Interview with the Assistant Director of Nursing in the music room on November 9, 2011, at 2:39 p.m., confirmed the top of the medication cart was considered dirty; and the facility failed to administer medication in a sanitary manner.</p> <p>Resident #523 was admitted to the facility on October 25, 2011, with diagnoses including Anemia, Hyponatremia, Hypokalemia, Acute Left Temporoparietal Infarct, and Nonsustained Ventricular Tachycardia.</p> <p>Medical record review revealed the resident was</p>	F 441	<p>Other patients/residents with the potential to be affected by this deficient practice are any and all patients with orders to receive medications and/or be in isolation.</p> <p>Measures to be put into place to ensure deficient practice does not reoccur are as follows Ongoing observations are now being conducted by the Nursing Leadership staff, Quality Nurse Educator and Charge Nurses. Monitoring has been conducted on 11/10/11 by the PCC's, ADON, Quality Control Nurse and DON to ensure there are no other like situations with this deficient practice. These ongoing observations will be random and unannounced to staff-- (to include all patients in isolation). In addition, to ensure this deficient practice does not reoccur the Isolation Policy & Procedure will be reviewed immediately with staff present and in the Unit meeting on Tuesday November 29, 2011. In addition, changes were made to the current facility's Isolation Precautions Policy and Procedure and to the Nursing Unit Communication Device Usage to reflect this change. "Staff must remove gloves and wash hands before touching the microphone on the two-way radio".</p> <p>These corrective actions will be monitored primarily by the Nursing Leadership staff and the Quality Nurse Educator by observing patients/residents in Isolation or receiving medications to proactively manage proper infection control. Any failures to maintain proper infection control when administering medications, when entering an isolation room or giving care to a patient in isolation will result in further education and/or disciplinary action. Basic Infection Control Practices were reviewed with all employees in orientation and each nurse has signed the Infection Control Agreement form that is in each employee's education file. The Basic Infection Control Practices will be reviewed/educated and monitored quarterly by the Quality Nurse Educator and the Nursing Leadership Staff.</p>	

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F 441	<p>Continued From page 7</p> <p>placed in Contact Isolation on November 6, 2011, due to stool cultures positive for Clostridium Difficile (C-Diff) (an infectious bacteria), and urine culture positive for Vancomycin Resistant Enterococcus.</p> <p>Observation on November 7, 2011, at 11:50 a.m., revealed Certified Nurse Assistant (CNA) #3 entered the resident's room, and carried a lunch tray with ungloved hands. CNA #3 then placed the resident's lunch on the overbed table, and opened the lunch items for the resident. The table was in front of the resident who was sitting in a recliner at bedside. After completing this task, CNA #1 washed the hands and exited the room. Continued observation revealed a Contact Isolation sign was posted on the outside of the door, which said "wear gloves when entering room".</p> <p>Interview with CNA #3 on November 7, 2011, at 11:53 a.m., in the hallway outside the resident's room, confirmed CNA #3 had not worn gloves when delivering and setting up the resident's tray.</p> <p>Review of facility policy, Isolation Precautions, revealed in Section II-H-3-a in reference to Contact isolation precautions "...In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, non-sterile) when entering the room..."</p> <p>Interview with the ADON on November 8, 2011, at 7:15 a.m., in the ground floor nurse's station, confirmed gloves are to worn when entering a Contact Isolation room to provide care or services.</p>	F 441	<p>The ongoing Quality Measuring results on administering medications, upon entering an isolation room & caring for a patient while in isolation and preventing contamination will be discussed with the nursing staff at each monthly unit meeting and/or in the nursing newsletter.</p>	

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F 441	Continued From page 8 Interview with the Infection Control Coordinator on November 8, 2011, at 8:40 a.m., in the ground floor nurse's station, confirmed the facility policy required staff to wear gloves when entering the room of a resident in contact isolation; and the CNA failed to adhere to follow isolation guidelines. Resident #525 was admitted to the facility on October 28, 2011, with diagnoses including End Stage Renal Disease, Hypertension, and Urinary Tract Infection. Medical record review of the physician's orders revealed the resident was placed in contact isolation due to C-Diff on November 5, 2011. Observation on November 10, 2011, at 10:15 a.m., of the resident's room, revealed a sign stating use contact isolation precautions. Observation on November 10, 2011, at 10:20 a.m., in the resident's room revealed Certified Nurse Assistant (CNA) #1 entered the resident's room put on a isolation gown and gloved both hands. Continued observation revealed CNA #1 touched the resident's chair, call light, blanket, and pillow, then without changing the gloves or washing the hands reached inside the uniform top and pulled the microphone out (used to communicate with other staff), four times and communicated with another CNA. Continued observation revealed CNA #1 without changing the gloves or washing the hands, touched the resident's gait belt, bathroom door knob, hand rails used by the resident to lower self to the	F 441			

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

PRINTED: 11/15/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445404	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/10/2011
NAME OF PROVIDER OR SUPPLIER BLOUNT MEMORIAL TRANS CARE CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804		
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F 441	<p>Continued From page 9 toilet, the pant-legs of the uniform, and the resident's pants and brief.</p> <p>Review of the facility's Isolation Precautions Policy and Procedures revealed, "...In addition to Standard Precautions, Contact Precautions must be implemented for residents known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or patient-care items in the resident's environment...Examples of infections requiring Contact Precautions include...Clostridium difficile..."</p> <p>Interview on November 10, 2011, at 10:38 a.m., with CNA #1 in the resident's room confirmed the gloved hands were contaminated when the CNA touched the resident's personal items and toilet hand rails. Continued interview confirmed the uniform and microphone were contaminated when touched, and the contact isolation policy was not followed.</p>	F 441			