

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445292	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/06/2011
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NAME OF PROVIDER OR SUPPLIER  BEECH TREE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 240 HOSPITAL LANE, PO BOX 300 JELICO, TN 37762
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F 328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services:                  Injections;                  Parenteral and enteral fluids;                  Colostomy, ureterostomy, or ileostomy care;                  Tracheostomy care;                  Tracheal suctioning;                  Respiratory care;                  Foot care; and                  Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by:                  Based on medical record review, observation, facility policy review, and interview the facility failed to demonstrate the safe transport of oxygen tanks for one resident (#21) of twenty-one residents reviewed.</p> <p>The findings included:</p> <p>Resident #21 was admitted to the facility on June 22, 2010, with diagnoses including Left Lower Lobe Pneumonia, End Stage Chronic Obstructive Pulmonary Disease, and Congestive Heart Failure.</p> <p>Medical record review of the physician's recapitulation orders dated January 2011, revealed "...O2 (oxygen) at 3 - 4 L (liters) via N/C (nasal cannula)..."</p> <p>Observation on January 5, 2011, at 12:04 p.m., from the 300 hall nurses station, revealed Certified Nurse Assistant (CNA) #4 entered the</p>	F 328	<p>This Plan of Correction is prepared and executed because it is required by the provisions of State and Federal law and not because Beech Tree Manor agrees with allegation(s) and citation(s) listed on this Statement of Deficiencies. Beech Tree Manor maintains that the alleged deficiencies do not individually or collectively constitute substandard care or jeopardize the health and safety of the residents; nor are they of such character so as to limit our capability to render adequate care. This Plan of Correction shall also serve as the facility's written Credible Allegation of Compliance.</p> <p>F 328                  The Oxygen Tank Storage and Handling Policy was immediately reviewed and revised to include the transporting of oxygen tanks. The facility has determined that all residents have the potential to be affected. All facility personnel involved in the transport and storage of oxygen will be educated regarding the revised policy. A new oxygen transport cart, that will accommodate multiple tanks, has also been ordered. The Administrator and Director of Nursing will conduct random observations of staff over the next 60 days to ensure staff are adhering to the newly revised Oxygen Tank Storage and Handling Policy. Results of those random observations will be reported in the monthly Quality Assurance Committee Meeting.</p>	1/29/11
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Charles W. Wheeler, NHA</i>	TITLE <i>Administrator</i>	(X6) DATE <i>1-26-2011</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 328	<p>Continued From page 1</p> <p>oxygen storage area with the resident's family member and hand-carried two oxygen tanks from the storage area. Continued observation revealed the family member hand-carried one oxygen tank from the storage area.</p> <p>Observation at this time with Licensed Practical Nurse #1 revealed two tanks were carried to the resident's room and placed upright on the floor in preparation for the resident to leave the facility with family members. Continued observation revealed resident #21 seated in a wheelchair, with oxygen being administered from an oxygen tank secured to the back of the wheelchair.</p> <p>Review of the facility's policy, Oxygen Tank Storage and Handling, revealed no guidance for transporting oxygen tanks from one location to another.</p> <p>Interview on January 5, 2011, at 12:10 p.m., with Licensed Practical Nurse #1 at the 300 hall nurse's station, confirmed oxygen tanks were to be secured in the rolling dolly for transport.</p> <p>Interview with the Administrator on January 6, 2011, at 1:05 p.m., in the administrator's office, confirmed manually carrying the oxygen tanks was "probably not the safest method of transport" and was not aware the policy, Oxygen Tank Storage and Handling, did not address transporting oxygen tanks.</p>	F 328		
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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</p>	F 441		

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F 441	<p>Continued From page 2 of disease and infection.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, facility policy, and interview, the facility failed to distribute ice in a sanitary manner on one of four hallways.</p>	F 441	<p>F 441 The Certified Nursing Assistants involved were immediately in-serviced on the proper procedure for distributing ice. The facility has determined that all residents have the potential to be affected. All facility staff involved in the passing of ice will be re-educated on the proper procedure for passing ice. Two new ice carts, with attached ice scoop holders, have been ordered. The Director of Nursing and Assistant Director of Nursing will conduct random observations of staff over the next 60 days to ensure staff are adhering to the proper procedure for passing of ice. Results of those random observations will be reported in the monthly Quality Assurance Committee Meeting.</p>	1/29/11	

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

PRINTED: 01/06/2011  
FORM APPROVED  
OMB NO. 0938-0391

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F 441	<p>Continued From page 3</p> <p>The findings included:</p> <p>Observation on January 4, 2011, at 2:30 p.m., on the 300 hallway, revealed CNA #1, #2, #3, (certified nursing assistant) distributing ice to the residents. Continued observation revealed CNA #2 came out of room 304 brought the water container to the ice chest, retrieved the ice scoop from the ice chest (clean ice) with ungloved hands, scooped ice into the water container, placed the ice scoop back into the ice chest. Continued observation revealed CNA #2 returned the ice containers back to the room 304, proceeded to room 305, retrieved ice container one at a time, takes to the ice chest, retrieved ice scoop from the ice chest (clean ice) with ungloved hands, scooped ice into the container and returned the container to room 305. Continued observation revealed CNA #3 entered into room 306, retrieved the water container, proceeded to the ice chest, retrieved the ice scoop from the chest with ungloved hands, scooped ice into the container, placed the ice scoop back into the ice chest, and returned the container to room 306. Further observation revealed CNA #1 proceed to rooms 307 and room 308, retrieved the water container from each room one at a time, proceeded to the ice chest, retrieved the ice scoop from the ice chest with ungloved hands, scooped ice into the water container, placed the ice scoop back into the ice chest, and returned each of the water container back to the room 307 and 308.</p> <p>Review of the facility's policy Passing Fresh Ice/Water revealed "...2. Properly uses and stores ice scoop. 3. Does not allow ice to touch hand and fall back into container. 4. Scoop placed in appropriate receptacle after each use."</p>	F 441		
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F 441	<p>Continued From page 4</p> <p>Interview with CNA #1 and #2, on January 4, 2011, at 2:50 p.m., on the 300 hallway, confirmed the ice scoop was not to be left in the ice chest.</p> <p>Interview with the Director of Nursing on January 5, 2011, at 2:00 p.m., in the conference room, confirmed the facility did not follow the facility's policy for the ice pass.</p>	F 441		