

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

PRINTED: 07/21/2011
FORM APPROVED
OMB NO. 0938-0391

454 9/02/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445427	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/19/2011
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NAME OF PROVIDER OR SUPPLIER BETHESDA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 444 ONE ELEVEN PLACE COOKEVILLE, TN 38501
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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
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F 000 INITIAL COMMENTS

F 000

During the annual recertification survey conducted on July 17 - 19, 2011, at Bethesda Health Care, complaint #TN00027872 was investigated.

F 281 SS=D 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

F 281

483.20(k)(3)(i) Services Provided Meet Professional Standards SS=D

The services provided or arranged by the facility must meet professional standards of quality.

Requirement:
The services provided or arranged by the facility will meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, review of manufacturer's instructions, observation and interview the facility failed to ensure the medication nurse instructed the resident prior to administering an inhaled medication for one (#21) of twenty-five residents reviewed.

Corrective Action:
1. On 7/19/11, Resident #21 was assessed by DON for accuracy of administration of medication.
2. On 7/19/11 audit was conducted by DON and ADON of residents in facility who received inhalation medication to ensure that proper technique was followed in the administration of the medication.
3. On 8/1/11 inservice of nursing staff was conducted by DON and ADON to ensure proper techniques were followed during the administration of an inhaled medication.
4. The facility DON, ADON, and/or Risk Management Nurse to monitor for compliance through weekly observations X30 days, if compliance is maintained decrease audits to monthly X3 months. Findings will be reviewed in Quality Assurance Committee.

The findings included:

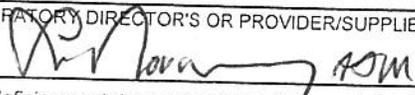
Resident #21 was admitted to the facility on May 12, 2008, with diagnoses including Chronic Airway Obstruction, and Dysphagia.

Medical record review of the Minimum Data Set dated July 13, 2011, revealed the resident was able to make self understood and usually understands most conversation.

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Medical record review of the Physician's Recapitulation Orders dated June 6, 2011, revealed, "...Spiriva (an inhaled medication used for breathing difficulties)...one puff every day..."

Observation of Licensed Practical Nurse (LPN) #

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 8/3/11
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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 281	<p>Continued From page 1</p> <p>1 in the resident's room on July 18, 2011, at 8:05 a.m., revealed LPN #1 administered the Spiriva and failed to give instruction on the medication prior to administration. Continued observation revealed the resident took one quick puff without holding the breath or breathing out completely.</p> <p>Review of the manufacturer's instructions revealed, "...breathe out completely...Breathe in slowly and deeply...Hold your breath as long as comfortable..."</p> <p>Interview with LPN #1 on July 18, 2011, at 9:30 a.m., on the 600 hall, confirmed the medication was administered without first instructing the resident on the proper technique.</p> <p>Interview with the Assistant Director of Nursing (ADON) on July 18, 2011, at 9:43 a.m., in the ADON office confirmed the facility failed to follow the manufacturer's instruction for Spiriva administration.</p>	F 281		
F 315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 315	<p>483.25(d) No Catheter, Prevent UTI, Restore Bladder SS=D</p> <p><u>Requirement:</u> The facility will 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 will receive appropriate treatment and services to prevent UTI's and to restore as much normal bladder function as possible.</p>	

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F 315 Continued From page 2
by:
Based on medical record review, facility policy review, and interview the facility failed to complete bladder assessments to develop a toileting plan for two (#6, and #14) of twenty-five residents reviewed.

The findings included:

Resident #6 was admitted to the facility on August 29, 2009, with diagnoses including Anemia, Atrial Fibrillation, Diabetes, Osteoporosis, Congestive Heart Failure, and Hypothyroidism.

Medical record review of the Minimum Data Set (MDS) dated May 18, 2011, revealed the resident was frequently incontinent and a trial toileting program had not been attempted on admission to the facility.

Medical record review of an undated 72 Hour Bowel and Bladder Record revealed the resident was wet (incontinent) thirty times during the 72 hours. Continued review of the reverse side of the 72 Hour Bowel and Bladder Record revealed the Nurse Evaluation of the 72 Hour Bowel and Bladder Record was not completed to implement a toileting program.

Review of the facility's policy Bowel and Bladder Program revealed "Each patient who is incontinent should be identified, assessed, and provided with individualized treatment and services to achieve or maintain as normal elimination function as possible...If the patient is identified as incontinent you must initiate a 72 Hour Bowel and Bladder Record...The Restorative Nurse/Designee will be responsible

F 315

Corrective Action:
1. On 7/19/11 the 72 Hour Bowel and Bladder assessment was completed on Resident #6 and Resident #14 and a toileting plan was initiated on both residents.
2. On 8/1/11 audit was completed by Restorative Nurse to ensure that Bowel and Bladder assessments were completed and toileting plan in place for residents within facility.
3. On 8/1/11 inservice of nursing staff was conducted by DON and ADON to ensure proper procedures were followed for residents on the Bowel and Bladder program.
4. The facility Risk Management Nurse to monitor for compliance through daily audits of new admissions X3 months. Medicare Admission Nurse to initiate Bowel and Bladder assessment upon admission of new resident. Restorative Nurse to monitor the initiation and completion of the Bowel and Bladder program weekly X3 months, if compliance is maintained decrease audits to monthly X3 months. Findings will be reviewed in Quality Assurance Committee.

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F 315 Continued From page 3
for monitoring the initiation and completion of this process...The Restorative Nurse/Designee must review the form and determine the type of toileting program to initiate and indicate the urinary and bowel plan on the back of the 72 Hour Bowel and Bladder Record..."

Interview on July 18, 2011, at 10:15 a.m., with Licensed Practical Nurse (LPN) #2 (Restorative Nurse), in the conference room, confirmed after the 72 Hour Bowel and Bladder Record was completed, the record was not assessed to determine an individualized bladder retraining program for the resident.

Resident #14 was admitted to the facility on June 7, 2011, with diagnoses including Dementia, Essential Tremors, Depressive Disorder, and Anxiety.

Medical record review of the MDS dated June 14, 2011, revealed the resident was frequently incontinent of bladder.

Medical record review of an admission Bladder Assessment dated June 7, 2011, revealed the resident had greater than seven episodes of incontinence in the last seven days. Continued review of the Bladder Assessment revealed "...If the patient has incontinent episodes, initiate a 72 Hour Bowel & Bladder Record to identify pattern..."

Medical record review revealed no documentation a 72 Hour Bowel & Bladder Record was completed.

Interview on July 18, 2011, at 2:35 p.m., with

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F 315	Continued From page 4 Registered Nurse (RN) #1, in the conference room, confirmed a 72 Hour Bowel & Bladder Record had not been completed, and a bladder retraining program had not been established for the resident.	F 315		
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 adequate assistance with ambulation/toileting for two (#14, #19) and failed to ensure a safety device was in place for one (#8) of twenty-five residents reviewed. The findings included: Resident #14 was admitted to the facility on June 7, 2011, with diagnoses including Dementia, Essential Tremors, Depressive Disorder, and Anxiety. Medical record review of the Minimum Data Set (MDS) dated June 14, 2011, revealed the resident required extensive assistance of two persons with ambulation and had fallen in the month prior to admission to the facility.	F 323	483.25(h) Free of Accident Hazards/Supervision/Devices SS=D <u>Requirement:</u> The facility will ensure that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. <u>Corrective Action:</u> 1. a. On 8/1/11 Resident #14 was reviewed by Falls Risk Nurse for proper fall risk procedures. Physical Therapy provided updated fall screen for resident. Communication sheet audited to ensure that accurate information is listed for nursing staff to follow. b. On 8/1/11 Resident #19 was reviewed by Falls Risk Nurse for proper fall risk procedures. Nurse communication sheet was reviewed to ensure correct information was available for nursing staff to follow. c. On 7/18/11 visual inspection of resident #8 was conducted by Falls Risk Nurse to ensure that alarm was in place and functioning properly. 2. a. and b. On 7/19/11 nurse aide documentation sheets were audited by Fall Risk Nurse to ensure that communication sheets accurately reflected residents required level of assistance. c. On 7/19/11 Fall Risk Nurse completed visual audit of residents requiring safety alarms to ensure that alarms were in place and were functioning properly.	

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F 323

Continued From page 5

Medical record review of a Fall Risk Assessment dated June 7, 2011, revealed the resident was at moderate risk for falls.

Medical record review of a Physical Therapy Certification signed by the physician on June 8, 2011, revealed "...Pt (patient) requires min-mod assist x (times) 1 to maintain balance with Poor standing balance all aspects using RW (rolling walker)..."

Medical record review of a Nurse's Event Note dated June 11, 2011, at 1:20 p.m., revealed "...CNA (Certified Nursing Assistant) walking beside pt (patient) while pushing another pt. Pt walking with walker from dining room. Pt states 'I lost my balance et (and) fell...Bruise to (L) (left) wrist area under pt's watch..."

Observation on July 18, 2011, at 2:25 p.m., revealed the resident seated in a recliner, beside the bed with a safety alarm in place.

Interview on July 18, 2011, at 2:55 p.m., with the Physical Therapist, in the conference room, revealed min-mod assist meant the resident required hands on assist when ambulating and a gait belt was to be used.

Interview on July 18, 2011, at 3:35 p.m., with the Director of Nursing, in the conference room, confirmed the resident did not have hands-on assistance at the time of the fall on June 11, 2011.

Interview on July 19, 2011, at 7:35 a.m., with Certified Nursing Assistant (CNA) #1, in the

F 323

3. On 8/1/11 inservice of nursing staff was conducted by DON and ADON to ensure proper procedures were followed for residents who required fall risk monitoring and those who used safety devices to prevent falls.

4. The facility Falls Risk Nurse, Risk Management Nurse, DON, and/or ADON will complete daily audits X60 days, if compliance is maintained decrease audits to weekly X90 days. Findings will be reviewed in Quality Assurance Committee.

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F 323	<p>Continued From page 6</p> <p>hallway, revealed on June 11, 2011, at the time of the resident's fall, CNA #1 had been assigned to the dining room. Continued interview revealed CNA #1 was responsible for assisting residents back to their rooms after completing the lunch meal. Continued interview revealed CNA #1 was not aware the resident required assistance with ambulation at the time of the fall, and confirmed the resident was unassisted at the time of the fall. Resident #19 was admitted to the facility on June 23, 2007, with diagnoses including Cerebral Vascular Accident with Encephalopathy, Atrial Fibrillation, and Dementia.</p> <p>Medical record review of the Minimum Data Set dated January 26, 2011, revealed the resident required extensive assistance of one person for toilet use.</p> <p>Medical record review of a nurse's note dated February 25, 2011, at 10:58 p.m., revealed, "...In hallway when overheard a loud noise and resident yelling out. Went into resident bathroom with CNA resident found laying on right side on floor...no apparent injury..."</p> <p>Interview with the Director of Nursing on July 19, 2011, at 8:02 a.m., in the Staffing Coordinator office confirmed the resident required extensive assistance for toilet use and was left unsupervised at the time of the fall.</p> <p>Resident #8 was admitted to the facility on November 3, 2006, with diagnoses including Cerebrovascular Accident, Coronary Artery Disease, Osteoarthritis, and Hypertension.</p>	F 323		
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F 323	<p>Continued From page 7</p> <p>Medical record review of the fall risk assessment dated February 8, 2011, and March 19, 2011, revealed the resident was at high risk for falls.</p> <p>Medical record review of the physician's recapitulation orders dated January 1, 2011, through January 31, 2011, and March 1, 2011, through March 31, 2011, revealed, "...Body/Chair Alarm..."</p> <p>Medical record review of the Nurse's Event Note dated February 8, 2011, revealed, "...Resident sitting in w/c (wheelchair) (at) nurse's station. Continuously leaning forward in chair, staff had to sit back several times. Pt (patient) leaned too far forward and fell head first in floor. Has large blue knot to (left) side of head..." Continued review of the Nurse's Event Note dated February 8, 2011, revealed no documentation the alarm was in place.</p> <p>Medical record review of the Nurse's Event Note dated March 19, 2011, revealed, "...roommate was yelling "come help" pt found on floor beside bed...only injury noted to be scratch to (upper)...back..." Review of the facility investigation dated March 19, 2011, revealed, "...Alarm ordered prior to occurrence...(yes circled)...If so, was it in place...(no circled)...Alarm put in place (after) fall (and) CNA's (certified nursing assistant) reminded to (check)..."</p> <p>Observation on July 18, 2011, at 7:30 a.m., revealed the resident in the dining room seated in a geri chair with a chair alarm attached to the resident's shirt.</p> <p>Interview on July 18, 2011, at 8:50 a.m., in the</p>	F 323		
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F 323	Continued From page 8 conference room, with LPN (Licensed Practical Nurse) #1, confirmed it was unknown if the alarm was in place and functioning at the time of the fall on February 8, 2011, and the alarm was not in place at the time of the fall on March 19, 2011.	F 323		
F 428 SS=D	C/O TN 27872 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of pharmacy recommendations, and interview, the facility failed to ensure pharmacy recommendations were implemented timely for one resident (#7) of twenty-five residents reviewed. The findings included: Resident #7 was admitted to the facility on January 11, 2006, with diagnoses including Anemia, Osteoarthritis, and Parkinson's Disease.	F 428	483.60(c) Drug Regimen Review, Report Irregular, Act On SS=D <u>Requirement:</u> The drug regimen of each resident will be reviewed at least once a month by a licensed pharmacist. <u>Corrective Action:</u> 1. On 7/18/11 drug regimen for Resident #7 was reviewed by DON and ADON. Corrections for duplication orders were addressed to ensure accurate medication administration. 2. On 7/18/11 pharmacy recommendations for residents were audited by DON and ADON to ensure timely notification of physicians. 3. On 8/1/11 inservice of nursing staff was conducted by DON and ADON to ensure proper procedures were followed for processing pharmacy recommendations timely. 4. The facility DON, ADON, Risk Management Nurse and Pharmacist will complete weekly audits X 60 days, if compliance is maintained decrease audits to monthly X3 months. Findings will be reviewed in Quality Assurance Committee.	08/01/11

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F 428	<p>Continued From page 9</p> <p>Review of the pharmacy recommendation dated February 21, 2011, and faxed to the physician on April 18, 2011, revealed, "...This resident currently has orders for Famotidine (anti-ulcer) and Omeprazole (anti-ulcer), which may constitute a duplication of therapy. Please review these orders and document if both medications are necessary. Otherwise, please consider discontinuing one of these orders...Response: D/C (discontinue) Famotidine (signed by the physician on April 19, 2011)..."</p> <p>Review of the pharmacy recommendation dated March 24, 2011, and faxed to the physician on April 18, 2011, revealed, "...This resident currently has orders for Perphenazine (antipsychotic) 2mg (milligrams) hs (bedtime) and Seroquel (antipsychotic) 200mg hs, which may constitute a duplication of therapy. Please review these orders and document if both medications are necessary. Otherwise, please consider discontinuing one of these orders...(unsigned by the physician as of July 18, 2011)"</p> <p>Interview on July 18, 2011, at 3:15 p.m., in the conference room, with the Director of Nursing, confirmed a delay in notifying the physician of the pharmacy recommendations.</p>	F 428		
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 of disease and infection.</p> <p>(a) Infection Control Program</p>	F 441	<p>483.65 Infection Control, Prevent Spread, Linens SS=D</p> <p><u>Requirement:</u> The facility will 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.</p>	

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NAME OF PROVIDER OR SUPPLIER BETHESDA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 444 ONE ELEVEN PLACE COOKEVILLE, TN 38501
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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
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F 441	Continued From page 10 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 infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview. the facility failed to follow appropriate infection control practices related to nebulizers for two (#24, #25) of twenty-five residents reviewed. The findings included:	F 441	<u>Corrective Action:</u> 1. On 7/17/11 nebulizers for Residents #24 and #25 were placed in blue protective bags to follow appropriate infection control practices. 2. On 7/17/11 audit was conducted by DON, ADON, Staff Coordinator, and Risk Management Nurse to ensure that nebulizers used by residents, when not in use, were placed in blue protective bags for purposes of infection control. 3. On 8/1/11 inservice of nursing staff was conducted by DON and ADON to ensure proper procedures were followed for storing resident's nebulizers when not in use. 4. The facility DON, ADON, Staffing Coordinator and/or Risk Management Nurse to monitor for compliance through weekly observations X30 days, if compliance is maintained decrease audits to monthly X3 months. Findings will be reviewed in Quality Assurance Committee.	08/01/11
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AUG 23 2011

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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445427	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/19/2011
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F 441	<p>Continued From page 11</p> <p>Observation during the initial facility tour on July 17, 2011, at 9:00 a.m., revealed the face masks of the nebulizers for residents #24 and #25 were lying uncovered on the bedside tables.</p> <p>Interview with the Charge Nurse for 100 Hall on July 17, 2011, at 9:45 a.m., in the resident's room, confirmed the nebulizer for resident #24 was uncovered and should have been placed in the blue bag provided for nebulizers. Continued interview revealed it is the facility policy that nebulizers are to be covered when not in use.</p> <p>Interview with the Charge Nurse for 300 Hall on July 17, 2011, at 10:10 a.m., in the resident's room, confirmed the nebulizer for resident #25 was uncovered and should have been placed in the blue bag provided for nebulizers.</p> <p>Interview with the Director of Nursing on July 18, 2011, at 2:30 p.m., in the conference room, revealed there was no facility policy for care of nebulizers but it was an expectation the nebulizers would be placed in the blue bags when not in resident use.</p>	F 441		
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AUG 23 2011