**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
LIFE CARE CENTER OF BRUCETON-HOLLOW ROCK

**STREET ADDRESS, CITY, STATE, ZIP CODE**
105 ROWLAND
BRUCETON, TN 38317

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 223 SS=D</td>
<td>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</td>
<td>F 223</td>
<td>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On 2.10.14, Staff Development Coordinator completed an in-service with all staff regarding the facility abuse policy, which includes involuntary seclusion. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? On 2.20.14, Abuse Coordinator conducted random resident interviews to ensure no allegations of abuse. Result showed that facility is in compliance with its Protection of Residents: Reducing the Threat of Abuse and Neglect policy. Abuse Coordinator or designee will continue to do random interviews of residents weekly for four weeks, then monthly for two months, or until substantial compliance is obtained. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur? Staff Development Coordinator will continue to in-service all staff on the facility abuse policy, which includes involuntary seclusion, upon hire, during orientation, quarterly and as needed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Abuse coordinator will present findings to the Performance Improvement (PI) Committee. Performance Improvement Committee consists of: Medical Director, Executive Director, Director of Nursing, Business Office Manager, Dietary Manager, Activities Coordinator, Health Information Manager, Director of Rehab, Social Services Director, Environmental Services Manager, Marketing Director, Admissions Coordinator, Wound Care Nurse, Maintenance Director, Staff Development Coordinator, and Assistant Director of Nursing. Performance Improvement Committee will make recommendations as necessary.</td>
<td>2-20-14</td>
</tr>
</tbody>
</table>

**LAbORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**

**DATE**

F 223

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.
F 223 Continued From page 1

room and have staff watch her in her room. Nurse #3 instructed 2 Certified Nursing Assistants (CNAs #7 and #9) to put Resident #71 in her room and keep her there. The 2 CNAs did put the resident in her room and held the door closed until another nurse arrived and called the ADON to ask if she could take Resident #71 to the other side of the building with her to calm her down. The Director of Nursing (DON), the ADON, and the Executive Director confirmed they did not know about the treatment of Resident #71 until they returned to work on the Monday after the incidents. An investigation was performed once the were made aware of the incident.

Medical record review for Resident #71 documented an admission date of 10/7/09 with diagnoses of Dementia with Behavioral Disturbance, Osteoarthritis, Chronic Airway Obstruction, Depressive Psychosis, Bipolar Disorder, Coronary Artery Disease, Essential Hypertension and Diarrhea.

During an interview at the nurse's station #1 on 2/4/14 at 5:40 PM, CNA #7 was asked about the incident with Resident #71 on 11/1/13. CNA #7 stated, "...while I and another CNA, [CNA #9] were putting Resident #71 in her room Resident #71 slid out of her chair and landed in the floor. She had told us she was going to put herself in the floor..." CNA #7 was asked who was holding the door shut and why. CNA #7 stated, "...we both [CNA #7 and #9] were... because the nurse told us to keep her in her [Resident #71] room..." CNA #7 was asked for clarification if both of the CNAs were holding the door. CNA #7 stated, "Yes ma'am." CNA #7 was asked if Resident #71 ever attempted to come out of the room. CNA #7 stated, "...I think she pulled on the door twice."
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td></td>
<td></td>
<td></td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
</tr>
<tr>
<td>F 223</td>
<td></td>
<td></td>
<td>Continued From page 2</td>
<td>F 223</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

During an interview in the Social Worker's (SW) office on 2/4/14 at 5:45 PM, the SW was asked about her involvement in the incident with Resident #71 on 11/1/13. The SW stated, "I was originally involved on the night it occurred. The Nurse on call called me to ask my opinion, whether or not to call [Named Crisis] center and I told her we should after she explained to me what the Resident had done." The SW stated, "she has had behaviors in the past mostly verbal toward the staff never physical and she had reacted to [named Resident #5] before in an attempt to mother her to soothe her.

During an interview in the family room on 2/5/14 at 7:50 AM, CNA #4 was asked if she would put a resident in a room and hold the door closed? CNA #4 stated, "Absolutely not I would tell my charge nurse..."

During an interview in the DON's office on 2/4/14 at 3:20 PM, the DON confirmed, the staff involved were immediately suspended, when she was made aware of the incident. She conducted inservices related to abuse and treatment of the residents.

During an interview at nurses station #2 on 2/4/14 at 5:10 PM, Nurse #6 was asked if she recalled the incident from 11/1/13 and whether the door was closed to Resident #71's room. Nurse #6 stated, "Yes, the door was closed [named resident #71] was yelling but I don't think she was trying to get out." Nurse #6 was asked if the CNAs were holding the door. Nurse #6 stated, "They were." Nurse #6 stated, "One of the CNAs was but there were 2 down there..." Nurse #6 was asked who did she see holding the door. Nurse
Continued From page 3

#6 stated, "I think it was [named CNA #9]."

Resident #71 was involuntarily secluded by staff placing her in her room with the door shut and holding the door shut for 10 minutes with out visually monitoring of the resident.

**F 241**

483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

Based on the policy review, observation and interview, it was determined the facility failed to ensure 1 of 16 (CNA #1) staff members maintained a resident's dignity during dining when CNA #1 called a resident "Honey" repeatedly during the dining observation.

The findings included:

Review of the facility's "Courtesy Titles" policy which documented, "It is the policy of Life Care Center of Bruceton to use courtesy titles (MR., Mrs., Miss, Ms. or Dr [doctor]) when addressing patients and/or staff members."

Review of the facility's "Dignity" policy last revised 8/17/08 documented, "All residents are treated in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality."
F 241  Continued From page 4
Observations in the C/D activity room on 2/3/24 at 11:50 AM, CNA #1 was heard to call a resident "Honey" on 3 separate occasions while assisting the resident with lunch.

During an interview in the Director of Nursing's (DON) office on 2/4/14 at 11:50 AM, the DON was asked what her expectations were about calling residents by their names. The DON stated, "They're suppose to call them by the name they preferred... no, not honey, sweetie..."

F 253  483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:
Based on policy review, observation and interview, it was determined the facility failed to ensure the residents' environment was free from foul odors in 1 of 69 (room 206) resident rooms.

The findings included:
Review of the facility's "Daily Room Cleaning" policy documented, "...Provide a fresh, clean and sanitary environment during a resident's stay..."

Review of the facility's "Dignity" policy documented, "...All residents are treated in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality..."
F 253

Continued From page 5
Observations in room 206 on 2/3/14 at 2:40 PM, a wheelchair at the bedside with a pummel cushion that smelled of urine.

Observations in room 206 on 2/4/14 at 7:50 AM, the room smelled of urine.

Observations in room 206 on 2/5/14 at 10:47 AM and 12:20 PM, the room had a foul odor.

During an interview beside room 206 on 2/4/14 at 9:10 AM, certified nursing assistant (CNA) #5 was asked what the odor was in the room 206. CNA #5 stated, "...It is his [Resident #15] wound." CNA #5 was asked if she smelled urine. CNA #5 stated, "...I don't know, I may be just use to the odor but it is his wound..."

During an interview beside room 206 on 2/4/14 at 9:10 AM, CNA #6 was asked if she smelled anything in the room. CNA #6 stated, "I think it is his wound..."

F 280

483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,
Continued From page 6
and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation and interview, it was determined the facility failed to update the care plan with new interventions following a fall for 1 of 3 (Resident #83) sampled residents reviewed with falls of the 33 sampled residents included in the stage 2 review.

The findings included:
Review of the facility's "falls Management" policy documented, "...An interdisciplinary plan of care will be developed, implemented, reviewed and updated as necessary to reflect each resident's current safety needs and fall reduction interventions...d. An interdisciplinary care plan is developed as necessary to reflect each resident's current safety status, needs, and interventions...j. The charge nurse will review and update the care plan as needed to reflect the resident's present mobility, safety needs, and will communicate fall reduction interventions..."

Medical record review for Resident #83 documented an admission date of 10/25/12 with diagnoses of Alzheimer's Disease, Chronic Obstructive Pulmonary Disease, Hyperlipidemia, Osteoporosis, Hypertension and Dehydration. Review of the physician's orders dated 10/18/13
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 260 | Continued From page 7 | | "...2 nonskid strips to left side of bed..." Review of the falls care plan dated 11/6/12 was revised as followed:  
  a. 3/12/13 - "...lay resd [resident] down after meals."  
  b. 3/14/13 - "Antiroll back brakes to w/c [wheelchair]."  
  c. 9/26/13 - "Timed toileting @ [at] 12 AM & [and] 4 AM."  
  d. 10/13/13 - "Non-skid strips to L [left] side of bed..."  
  Review of the care plan dated 11/1/13 and revised 1/10/14 documented, "...Non-skid strips to floor L side of bed..."  
  Review of an incident follow-up & recommendation forms documented the following:  
  a. 10/17/13 - "FOLLOW-UP: Non skid strips to floor..."  
  b. 1/10/14 - "RECOMMENDATIONS/ACTIONS TAKEN: Non skid strips to left side of bed... FOLLOW-UP: 1/17/14 No further falls..."  
  During an interview in the family room 134 on 2/4/14 at 5:49 PM, Nurse #1 was asked about the same intervention of non-skid strips for falls on 10/18/13 and 1/10/14. Nurse #1 stated, "Didn't realize there was already nonskid strips in place..." | | | | | |
| F 314 | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES | | Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that | | | | | |

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 260</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 314</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Form CMS-2567(02-99) Previous Versions Obsolete**
Event ID: JFS911
Facility ID: TX09302
If continuation sheet Page 8 of 15
F 314 Continued From page 8
they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to ensure wound assessments are accurate for 1 of 3 (Resident #111) sampled residents reviewed with pressure ulcers.

The finding included:
Medical record review for Resident #111 documented an admission date of 11/26/13 with readmission date of 12/11/13 with diagnoses of Right Femur Fracture, Gastroesophageal Reflux Disease, Depression, Chronic Obstructive Pulmonary Disease, Insomnia, Osteoarthritis and Symbolic Dysfunction. Review of the Physician's orders dated 12/6/13 documented, "...clean coccyx... apply mediplex... low air mattress... 12/12/13 documented... clean coccyx with ns [normal saline], pat dry... apply melgisorb..."

Review of the initial data collection tool / nursing service for skin conditions documented the following:
a. 11/26/13 - "...General Skin Conditions... redden pale, bruises, skin tears, surgical scars, multiple pressure ulcers... stage 1... red heels... multiple pressure sores quantity 6..."
b. 12/11/13 - (readmission date) "...General Skin Conditions... DTI [deep tissue injury] was marked over the coccyx area of the anatomical drawing..."
F 314  Continued From page 9  
Stage 1 was checked."

During an interview in the family room 134 on 2/4/14 at 5:30 PM, the treatment nurse stated, 
"...when a resident is admitted the nurse documents a skin assessment... then I will look at 
it the next day and document my findings... I will stage wounds at that time... call the doctor if 
needed for treatment orders... on 12/6/13 the wound on his coccyx started to open... it was a 
stage 3 before he went to the hospital... on 12/11/13 when he came back from hospital the 
place on his coccyx was documented as a stage 1 and should have been stage 3... it was 
documented wrong by the nurse that did his admission assessment... I need to do some 
servicing on skin assessments..."

F 323  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, it was determined the facility failed 
to update the care plan with new interventions following a fall for 1 of 3 (Resident #63) sampled 
residents reviewed with falls of the 33 sampled residents included in the stage 2 review.
F 323  Continued From page 10

The findings included:

Review of the facility's "Falls Management" policy documented, "...An interdisciplinary plan of care will be developed, implemented, reviewed and updated as necessary to reflect each resident's current safety needs and fall reduction interventions... d. An interdisciplinary care plan is developed as necessary to reflect each resident's current safety status, needs, and interventions... j. The charge nurse will review and update the care plan as needed to reflect the resident's present mobility, safety needs, and will communicate fall reduction interventions..."

Medical record review for Resident #83 documented an admission date of 10/25/12 with diagnoses of Alzheimer's Disease, Chronic Obstructive Pulmonary Disease, Hyperlipidemia, Hypertension and Dehydration. Review of the physician's orders dated 10/18/13 documented, "...2 nonskid strips to left side of bed..." Review of the falls care plan dated 11/6/12 was revised as followed:

a. 3/12/13 - "lay resd [resident] down after meals."

b. 3/14/13 - "Antiroll back brakes to w/c [wheelchair]."

c. 9/28/13 - "Timed toileting @ [at] 12 AM & [and] 4 AM."

d. 10/18/13 - "Non-skid strips to L [left] side of bed..."

Review of the care plan dated 11/1/13 and revised 1/10/14 documented, "...Non-skid strips to floor to L side of bed..."

Review of an incident follow-up & recommendation forms documented the following:

F 323

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

On 2.5.14, Assistant Director of Nursing updated the care plan of Resident #83 with a new intervention, bringing the facility into compliance with the facility's Fall Management policy.

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

On 2.19.14, Assistant Director of Nursing completed an audit of all residents having a fall since 1.1.14 to ensure a new intervention was in place for every fall. The review proved the facility to be in compliance with its fall management policy.

What measures will be put into place or what systematic changes you make to ensure that the deficient practice does not recur?

On 2.10.14 the Director of Nursing, Staff Development Coordinator and the Assistant Director of Nursing conducted an in-service with all licensed staff on the facility's fall management protocol after a resident had a fall. Assistant Director of Nursing will audit all incidents of falls to ensure a new intervention is in place for every fall weekly for four weeks, then monthly for two months, or until substantial compliance is obtained.

How the corrective action[s] will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place?

Assistant Director of Nursing will present findings to the Performance Improvement (PI) Committee. Performance Improvement Committee consists of: Medical Director, Executive Director, Director of Nursing, Business Office Manager, Dietary Manager, Activities Coordinator, Health Information Manager, Director of Rehab, Social Services Director, Environmental Services Manager, Marketing Director, Admissions Coordinator, Wound Care Nurse, Maintenance Director, Staff Development Coordinator, and Assistant Director of Nursing. Performance Improvement Committee will make recommendations as necessary.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>445326</td>
<td>A. BUILDING ___________________</td>
</tr>
<tr>
<td></td>
<td>B. WING _____________________</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

**LIFE CARE CENTER OF BRUCETON-HOLLOW ROCK**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

105 ROWLAND
BRUCETON, TN 38317

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 323              | Continued From page 11  
a. 10/17/13 - "FOLLOW-UP: Non skid strips to floor..."  
b. 1/10/14 - "RECOMMENDATIONS/ACTIONS TAKEN: Non skid strips to left side of bed... FOLLOW-UP: 1/17/14 No further falls..."  
During an interview in the family room 134 on 2/4/14 at 5:49 PM, Nurse #1 was asked about the same intervention of non-skid strips for falls on 10/17/13 and 1/10/14. Nurse #1 stated, "Didn't realize there was already nonskid strips in place..." | F 323           |                                                                                                                  |                   |
| F 431              | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS                                              | F 431          |                                                                                                                  |                   |

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,
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

| (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 445326 |
| (X2) MULTIPLE CONSTRUCTION | |
| A. BUILDING | |
| B. WING | |
| (X3) DATE SURVEY COMPLETED | 02/05/2014 |

**NAME OF PROVIDER OR SUPPLIER**

LIFE CARE CENTER OF BRUCETON-HOLLOW ROCK

**STREET ADDRESS, CITY, STATE, ZIP CODE**

105 ROWLAND
BRUCETON, TN 38317

---

**F 431 Continued From page 12**

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.

This **REQUIREMENT** is not met as evidenced by:

Based on medical record review, observation and interview, it was determined the facility failed to store medication in a locked area for 1 of 33 (Resident #133) sampled residents included in the stage 2 review.

The findings included:


Observation in Resident #133's room on 2/3/14 at 5:18 PM, revealed an inhaler of Proventil on Resident #133's bedside table.

During an interview at nurses' station 2 on 2/3/14 at 5:18 PM, the Director of Nursing (DON) was asked about the Proventil on Resident #133's bedside table. The DON verified the medication

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 431</td>
<td>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</td>
</tr>
<tr>
<td>2-20-14</td>
<td>On 2.5.14, LPN removed the inhaler from the room of Resident #133 and sent it home with resident's family member, bringing facility into compliance with regulation regarding stored drugs.</td>
</tr>
</tbody>
</table>

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

On 2.6.14, Director of Nursing conducted a room audit of all residents who have orders for inhalers to ensure that no inhalers were at bedside without self-administration orders. The audit proved the facility to be in compliance with regulations regarding stored drugs.

What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?

On 2.10.14, Staff Development Coordinator conducted an in-service of all licensed staff regarding inhalers should only be at residents' bedside if resident has an order for self-administration of medicine. This in-service will be conducted by the Staff Development Coordinator upon hire, during orientation, and as needed. Director of Nursing or designee will conduct room checks on all residents with orders for inhalers to ensure that no inhalers are left at bedside without orders for self-administration of medicines weekly for four weeks, then monthly for two months, or until substantial compliance is obtained.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place?

Director of Nursing will present findings to the Performance Improvement (PI) Committee. Performance Improvement Committee consists of: Medical Director, Executive Director, Director of Nursing, Business Office Manager, Dietary Manager, Activities Coordinator, Health Information Manager, Director of Rehab, Social Services Director, Environmental Services Manager, Marketing Director, Admissions Coordinator, Wound Care Nurse, Maintenance Director, Staff Development Coordinator, and Assistant Director of Nursing. Performance Improvement Committee will make recommendations as necessary.
Continued From page 13

should not have been on the bedside table.

During an interview in Resident #133’s room on 2/5/14 at 3:30 PM, Resident #133 was asked about the inhaler that had been on his bedside table. Resident #133 stated, "The nurse took it and locked it up."

F 441 483.65 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
<table>
<thead>
<tr>
<th>Statement of Deficiencies and Plan of Correction</th>
<th>Date Survey Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>(X1) Providers/Supplier/CLA Identification Number: 445326</td>
<td>02/05/2014</td>
</tr>
<tr>
<td>(X2) Multiple Construction</td>
<td></td>
</tr>
<tr>
<td>A. Building</td>
<td></td>
</tr>
<tr>
<td>B. Wing</td>
<td></td>
</tr>
<tr>
<td>(X3) Date Survey Completed</td>
<td></td>
</tr>
</tbody>
</table>

**Name of Provider or Supplier:** Life Care Center of Bruceton-Hollow Rock  
**Street Address, City, State, Zip Code:** 165 Rowland, Bruceton, TN 38317

<table>
<thead>
<tr>
<th>(X4) ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>(X5) Completion Date</th>
</tr>
</thead>
</table>
| F 441              | Continued From page 14 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 policy review, observation and interview, it was determined the facility failed to ensure 1 of 16 (Certified Nursing Assistant (CNA) #2) staff members practiced hand hygiene to prevent the potential spread of infection.  
The findings included:  
Review of the facility's "Hand Hygiene" policy revised 5/21/04 documented, "...Handwashing / hand hygiene is generally considered the most important single procedure for preventing nosocomial infections..."  
Observations in the C/D hall activity room during the lunch meal on 2/5/14 at 11:55 AM, CNA #2 pulled her chair up to the table, took the resident's baby doll from her and moved it to her lap. CNA #2 then proceeded to feed the resident. CNA #2 handled the slice of bread and straw with her bare hands without performing hand hygiene.  
During an interview in the family room on 2/5/14 at 6:25 PM, the Director of Nursing (DON) was asked what her expectations were for handwashing during dining. The DON state, "If we [staff] touch anything in the environment or the resident... suppose to wash their hands..." | F 441  
What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  
On 2.6.14, Director of Nursing conducted an in-service with all CNAs who worked during the lunch meal in the C/D activity room on the facility's hand hygiene policy.  
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?  
On 2.14.14, Regional Director of Clinical Services completed an audit of the residents' dining experience to ensure staff was following facility's hand hygiene policy. Results show that facility is in compliance with its hand hygiene policy.  
What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?  
On 2.10.14, Staff Development Coordinator conducted an in-service of all staff regarding the facility's hand hygiene policy to prevent the potential spread of infection during dining. This in-service will be conducted by the Staff Development Coordinator upon hire, during orientation, and as needed. The Director of Nursing will audit by observation of handwashing during resident dining weekly for four weeks, then monthly for two months, or until substantial compliance is obtained.  
How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place?  
Director of Nursing will present findings to the Performance Improvement (PI) Committee. Performance Improvement Committee consists of: Medical Director, Executive Director, Director of Nursing, Business Office Manager, Dietary Manager, Activities Coordinator, Health Information Manager, Director of Rehab, Social Services Director, Environmental Services Manager, Marketing Director, Admissions Coordinator, Wound Care Nurse, Maintenance Director, Staff Development Coordinator, and Assistant Director of Nursing. Performance Improvement Committee will make recommendations as necessary. | 2-20-14 |
<table>
<thead>
<tr>
<th>Statement of Deficiencies and Plan of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>(X1) Provider/Supplier/CLIA Identification Number:</td>
</tr>
<tr>
<td>445326</td>
</tr>
<tr>
<td>(X2) Multiple Construction</td>
</tr>
<tr>
<td>A. Building ________________________________</td>
</tr>
<tr>
<td>B. Wing ________________________________</td>
</tr>
<tr>
<td>(X3) Date Survey Completed</td>
</tr>
<tr>
<td>02/05/2014</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Provider or Supplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Care Center of Bruceton-Hollow Rock</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Life Care Center of Bruceton-Hollow Rock</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address, City, State, Zip Code</td>
</tr>
<tr>
<td>105 Rowland</td>
</tr>
<tr>
<td>Bruceton, TN 38317</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(X4) ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>(X5) Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Received:**

Feb 24, 2014