F 000  INITIAL COMMENTS

A recertification survey and complaint investigation of #30804, #30890, and #31690, was conducted on May 13 through May 15, 2013, at Life Care Center of Tullahoma. No deficiencies were cited related to complaint investigation #30804 and #31690. Deficiencies were cited related to complaint investigation #30890 under 42 CFR Part 483, Requirements for Long Term Care Facilities.

F 279  DEVELP

S9-D  COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident’s comprehensive plan of care.

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.

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(g)(4).

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview;

-signature

Executive Director (6/1/13)

Very deficiency statement ending with an asterisk (*) disables a deficiency which the institution may be assessed from correcting providing it is determined that other safeguards provide equivalent protection to the patient. (See instructions) Excerpts for nursing homes, the findings stated above are illustrative to other steps allowing the state of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plan of correction are given by the closest 14 days following the date these documents are made available to the facility. If deficiencies are cited, an improved plan of correction is required to continued program participation.
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The facility failed to develop a care plan for the increased risk of bleeding related to a potential drug interaction for one resident (#82) of forty-one residents reviewed.

The findings included:

Resident #82 was admitted to the facility on August 9, 2006, with diagnoses including Alzheimer's Disease, Bipolar Disorder, Neuroleptic Mediated Movement Disorder, and Depressive Disorder.

Medical record review of a significant change Minimum Data Set (MDS) dated March 14, 2013, revealed the resident scored three out of fifteen on the Brief Interview for Mental Status indicating severely impaired cognitive skills. Continued review revealed the resident required limited assistance from one person for transfers, toileting, personal hygiene, and bathing.

Review of a Physician's Order dated April 5, 2013, revealed Zoloft (a selective serotonin reuptake inhibitor) 100 milligrams to be given orally on a daily basis for depression.

Review of the Physician's Recertification Orders dated May 2013, revealed the resident had an order for Ibuprofen (non-steroidal anti-inflammatory drug (NSAID)) 400 milligrams to be given orally every four to six hours as needed for pain.

Review of the Pharmacy's Potential Drug Interaction Alert dated April 8, 2013, revealed:

- Drug Interactions: Sertraline HCl (generic for Zoloft)...100 mg tablet. Interacts with Ibuprofen 400 mg...Patient Management: Selective...
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(a) PROVIDER/SUPPLIER IDENTIFICATION NUMBER
448228

(b) MULTIPLE CONSTRUCTION
A BUILDING

(c) DATE SURVEY COMPLETED
05/07/2013

NAME OF PROVIDER OR SUPPLIER
LIFE CARE CENTER OF TULLAHOMA

STREET ADDRESS, CITY, STATE, ZIP CODE
1728 N JACKSON ST
TULLAHOMA, TN 37386

(k) ID PRELIMINARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRERECIED BY FULL REGULATORY OR LIC IDENTIFYING INFORMATION)

(i) ID PRELIMINARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRERECIED BY FULL REGULATORY OR LIC IDENTIFYING INFORMATION)

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serotonin reuptake inhibitors...and NSAIDs should be used concurrently with caution.

Patients should be warned about the increased risk of bleeding and be educated about signs and symptoms of bleeding." Review of the Care Plan dated March 14, 2013, revealed no documentation for observations of increased risk of bleeding related to the potential drug interaction.

Interview with the MDS Coordinator in the MDS office on May 15, 2013, at 9:47 a.m., confirmed the MDS Coordinator had no knowledge of the Pharmacy alert, and stated "I have never seen that..." referring to the information provided on the Potential Drug Interaction menu. Continued interview confirmed a Care Plan for the increased risk of bleeding related to the potential drug interaction had not been developed.

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, review of the

F 323

A. What corrective action(s) will be accomplished for those residents found to have been affected:

On 4/24/13, Assistant Director of Nursing educated resident #4 who is alert and oriented to help ensure that he is transferred with 2 people. The associate was also trained on 2 person transfer during toileting and to view the care guides prior to delivering care.

4/24/2013

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

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Facility investigation, observation, and interview, the facility failed to ensure a safe transfer to prevent a fall for one resident (#4) of forty-one residents reviewed.

The findings included:

Resident #4 was admitted to the facility on May 13, 1989, and readmitted to the facility on July 20, 2007, with diagnoses including Cerebral Palsy, Anemia, Hypertension, and Esophageal Reflux.

Medical record review of the Quarterly Minimum Data Set dated February 3, 2013, revealed the resident was totally dependent with two person physical assistance for transfers and toileting.

Medical record review of the current Care Plan revealed the resident required total assistance with activities of daily living.

Medical record review of the Fall Risk Assessment dated February 14, 2013, revealed the resident was at risk for falls.

Observation on May 14, 2013, at 5:00 p.m., revealed the resident seated in a motorized wheelchair in the resident’s room.

Review of a facility investigation dated April 24, 2013, revealed “CNA (Certified Nursing Assistant) was transferring resident in BR (bathroom) from shower chair to wc (wheelchair). CNA began leaning forward and fell (with) resident hitting head against wall (no injury) educated resident on need for seat belt during transfer/resident declined placement of seat belt. Resident is two person assist. Education (with)

F 323 1) On 6/4/13 and annually at skills fair the Certified Nursing Aide, Licensed Practical Nurse, and Registered Nurse staff are trained by the Director of Nursing and Assistant Director of Nursing on proper transfer procedures and where information on resident transfers is located. 2) On 6/4/13 Director of Nursing completed an audit on resident care plans requiring two person assistance with transfers in relation to assistance given weekly for three months. 3) Director of Nursing and Assistant Director of Nursing will audit witness statements weekly during incident reporting and incidents to ensure substantial compliance.

6/4/2013

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

1) On 6/4/13, Education completed by Director of Nursing with Registered Nurse, Licensed Practical Nurse and Certified Nursing Aide associates to ensure compliance in assisting with transfers and Activities of Daily Living in relation to the care plan. 2) Room-to-room observation audit will be completed twice weekly for first month, then weekly for two months by Director of Nursing, Assistant Director of Nursing, and unit managers to ensure compliance with assistance with transfers. Corrections and education will be made at time of audit if needed.

6/4/2013

D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? i.e., what quality assurance program will be put into place.
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employee on 2 person transfer..."

Interview on May 16, 2013, at 7:30 a.m., with the
Director of Nursing (DON) in the Human
Resource Office, confirmed the resident was not
transferred correctly using two person assistance.

F 426 ACCURATE PROCEDURES, RPH

488.90(a)(1) PHARMACEUTICAL SVC -

The facility must provide routine and emergency
drugs and biologicals to its residents, or obtain
them under an agreement described in
§488.90(h) of this part. The facility may permit
unlicensed personnel to administer drugs if State
law permits, but only under the general
supervision of a licensed nurse.

A facility must provide pharmaceutical services
(including procedures that assure the accurate
acquiring, receiving, dispensing, and
administering of all drugs and biologicals) to meet
the needs of each resident.

The facility must employ or obtain the services of
a licensed pharmacist who provides consultation
on all aspects of the provision of pharmacy
services in the facility.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, review of a
facility investigation, facility policy review, and
interview, the facility failed to ensure the accurate
receipt of a medication-controlled drug for one
resident (823) of forty-one residents reviewed.

F 323 Results of transfer audits will be reported and
reviewed by the Performance Improvement
Committee which includes the Executive
Director, Medical Director, Director of Nursing,
Director of Marketing, Pharmacist, Director of
Admissions, Director of Social Services, Rehab
Services Manager, Director of Activities,
Director of Environmental Services, Dietary
Manager, and Staff Development Coordinator in
Monthly Performance Improvement Meeting and
corrections made as needed.

F 425 A. What corrective action(s) will be
accomplished for those residents found to have
been affected:

On 6/11/13 Licensed Practical Nurse and
Registered Nursing associates were in services
in proper following the controlled drug policy
by counting medications upon receipt from the
pharmacy.

B. 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 5/14/13 Director of Nursing and Assistant
Director of Nursing completed an audit of
controlled drugs to ensure compliance with
documentation of receipt of controlled drugs. All
controlled medications were accounted for.

C. What measures will be put into place or
what systematic changes will you make
to ensure that the deficient practice will
not recur?
The findings included:

Resident #20 was admitted to the facility on July 13, 2007, and readmitted on September 13, 2010, with diagnoses including Pneumonia, Acute Kidney Failure, Dysphagia, Psychosis, and Urinary Tract Infection.

Medical record review of the Physician's Consultation Orders dated December 2012, revealed the resident was to receive hydrocodone/acetaminophen (Lortab/pain medication) 5/325 mg (milligrams) by loading tube twice daily and every six hours as needed.

Medical record review of the December 2012, Medication Administration Record revealed the resident received the hydrocodone/acetaminophen 5/325 mg as ordered.

Review of a facility investigation revealed on December 28, 2012, thirty tablets of Lortab, were discovered to be missing, after a nurse had requested the Pharmacy to refill the prescription for the Lortab. Continued review of the facility investigation revealed the Pharmacy reported the Lortab had been delivered to the facility on December 23, 2012. Continued review of the facility investigation revealed an outdated signature of Licensed Practical Nurse (LPN) #1 as receiving the Lortab filled by Pharmacy on the evening of December 22, 2012. Continued review of the facility documentation revealed LPN #1 did not log the Lortab into the Narcotic Count Log (log of the number of proof of use sheets) when the medication was received. Continued
**F 426** Continued From page 6:

review of the facility investigation revealed the Loratab was not found.

Review of facility policy, Controlled Drugs, revised February 2008, revealed "...a controlled drugs
proof of use sheet is accurately maintained on all residents requiring controlled medications. Strict
care of narcotics is always maintained...appropriate storage, recording, and
use of controlled drugs are maintained on all units. Narcotic proof of use sheet is accurately
maintained on residents requiring such medication...The actual controlled drugs are
counted, as is the number of 'proof of use sheets' and the number of 'binger' cards (sleeves, bottles,
etc.) The 'proof of use sheets' should have their own sheets and are subtracted or added...".

Telephone interview on May 14, 2013, at 4:10
p.m., with LPN #1, revealed LPN #1 had received
the Loratab from the pharmacy on December 23,
2013. Continued interview confirmed the card of
Loratab tablets was not documented in the
notebook tracking the number of cards of
controlled medications (Narcotic Count Log).
Continued interview revealed the medication was
placed in the medication supply and the
Controlled Substance Drug Use Sheet was
placed into the notebook of controlled drugs at
the time the medication was delivered to the
facility. Continued interview confirmed the
facility's policy for Controlled Drugs was not
followed. Continued interview revealed LPN #1
denied taking the Loratab.

Interview on May 14, 2013, at 4:16 p.m., with the
Director of Nursing (DON), in the DON's office,
revealed on December 26, 2012, a Nurse had