1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practices:
Residents #95 and #117:
The Interdisciplinary Team (IDT) held a special care plan conference for Resident #95 on 12/20/2013. The plan of care has been reviewed and revised as indicated. Resident #95 was educated about dental needs and thereafter refused to seek additional treatment. The resident will be assessed for adverse effects related to dental status/decision daily during routine nursing care. Resident #117 no longer resides in the facility, he was discharged home on 12/6/2013 with Intrepid Home Health.

2) How will you identify other residents having risks for the same deficient practices and what corrective action will be taken:
a. Facility-wide resident dental assessments completed by the Team Leaders and the Social Services Director (SSD) - Completion Date: 12/20/2013.
b. On 12/18/2013, the Interdisciplinary Team (IDT) reviewed and revised all dental care plans. On 12/20/2013, the Director of Nursing and the Social Services Director reviewed the facility-wide dental assessments and interventions were implemented as indicated. Findings indicate that there are no other residents affected.
c. Director of Nursing (DON) and the RN Nurse Educator (NE) conducted a facility-wide audit of all dialysis residents on 12/19/2013. No additional residents were affected.
d. MDS team reviewed and revised all care plans related to dialysis on 12/19/2013.
Resident #95's dental record revealed Resident #95 had not been seen by a dentist since 12/14/12.

Observations and interview in Resident #95's room on 12/3/13 at 5:40 PM, with the surveyor and the MDS nurse present, revealed all of Resident #95's teeth on the lower right back side were brown in color. The MDS nurse stated she thought from the color of the teeth Resident #95 had cavities and confirmed she had not informed anyone.

During an interview in the MDS office on 12/3/13 at 5:35 PM, the MDS coordinator was asked about Resident #95's dental assessment on the MDS dated 7/13/13. The MDS coordinator stated when she asked the resident if her teeth hurt she touched her [right] jaw...

During an interview in the social worker's (SW) office on 12/3/13 at 5:40 PM, the SW was asked who informed her when someone had a dental problem and if she was notified of Resident #95's dental problem. The SW stated, "...team leaders or LPN's [licensed practical nurses] on the med cart...the Director of Nursing [DON] and Assistant Director of Nursing [ADON] let me know in the past [let her know if problem with teeth and need for dentist]. No [she was not made aware named Resident #95] needed to see the dentist...[if tooth pain] they [dentist] come immediately."

During an interview in the DON's office on 12/3/13 at 5:50 PM, the DON stated, "...If the MDS coordinator was aware, she should have notified social services...I expect her to tell somebody..."
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>N 611</td>
<td>Continued From page 2</td>
<td>N 611</td>
<td>1) What Corrective actions will be accomplished for those residents found to have been affected by those residents found to have been affected by the deficient practice;</td>
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<td></td>
<td>During an interview per telephone on 12/4/13 at 10:12 AM, the dentist was asked if Resident #95 had dental caries when he checked her. The dentist stated, &quot;It appears she does on the upper right (1) area, lower right (1) that I can see.&quot; The dentist was asked do not see any on the X-ray. The dentist stated, &quot;We saw her one time about a year ago. We saw her 12/2012. Obviously things could have changed... We thought she went home.&quot;</td>
<td></td>
<td>A. All affected utensils were discarded as well as all outdated food by the dietary manager immediately on 12-2-2013.</td>
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<td></td>
<td>B. The dietary manager replaced the affected utensils by ordering new ones on 12-6-2013. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</td>
</tr>
<tr>
<td>N 729</td>
<td>1200-8-6-.06(6)(b) Basic Services</td>
<td>N 729</td>
<td>C. Dietary manager amended daily checklist to include cooking utensil inspection for carbon build-up.</td>
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<td></td>
<td>(6) Pharmaceutical Services.</td>
<td></td>
<td>D. Dietary Manager and Administrator inspected and found no other affected utensils. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;</td>
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<td></td>
<td>(b) Poisons or external medications shall not be stored in the same compartment and shall be labeled as such.</td>
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<td></td>
<td>This Rule is not met as evidenced by: Second Assessed Type C Penalty #7</td>
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<tr>
<td></td>
<td>Tennessee Code Annotated 68-11-804(c)7 Poisons or external medications shall not be stored in the same compartment and shall be labeled as such.</td>
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<td></td>
<td>Based on policy review, observation and interview, it was determined the facility failed to ensure that biologicals and medications were stored properly in 2 of 7 (100 and 300 milliliter medication carts) medication storage areas.</td>
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<td>The findings included: 1. Review of the facility's medication storage</td>
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policy documented, "...Medications and biologicals are stored safely, securely, and properly... Potentially harmful substances... stored in a locked area separately from medications..."

2. Observations on the first floor on 12/4/13 at 1:55 PM, revealed the 100 hall medication cart had sanitizing wipes stored with spoons, straws and transparent dressings in the bottom drawer.

During an interview on the first floor on 12/4/13 at 1:55 PM, Nurse #5 confirmed that chemicals should be stored separate.

3. Observations on the second floor on 12/4/13 at 11:05 AM, revealed the 300 hall medication cart had a leaking container of sanitizing wipes that were stored with packages of Juven nutritional supplement, three loose pills were noted in a box in the fourth drawer and topical medications were stored with insulin needles in the bottom drawer.

During an interview on the second floor on 12/4/13 at 11:05 AM, Nurse #1 was asked if it was appropriate for chemicals to be stored with nutritional supplements. Nurse #1 stated, "...they're not supposed to store them here..." Nurse #1 was asked who is responsible for making sure the medication carts are clean and medications are stored properly. Nurse #1 stated, "...We [nurses] are..."

4. During an interview in the Director of Nursing's (DON) office on 12/4/13 at 2:08 PM, the DON was asked who is responsible for making sure items are stored properly on the medication carts. The DON stated, "...everybody who works on the [medication] carts should..."
N 767 1200-8-6-.06(9)(l) Basic Services

(9) Food and Dietary Services.

(j) Food shall be protected from dust, flies, rodents, unnecessary handling, droplet infection, overhead leakage and other sources of contamination whether in storage or while being prepared and served and/or transported through hallways.

This Rule is not met as evidenced by:
Second Assessed Type C Penalty #22

Tennessee Code Annotated 68-11-804(c)(22)
Food shall be protected from dust, flies, rodents, unnecessary handling, droplet infection, overhead leakage and other sources of contamination whether in storage or while being prepared and served and/or transported through hallways.

Based on policy review, observation and interview, it was determined the facility failed to ensure that foods were prepared, stored and served under sanitary conditions as evidenced of food stored past the expiration date and carbon built up on cookware during 1 of 2 (12/2/13) days of observations.

The findings included:

1. Review of the facility's "The Food Keeper" policy documented, "...refrigerate food to preserve freshness. However, over time, even chilled food begins to go bad. The Food Keeper charts indicate refrigerator storage times for a wide variety of food items calculated from the

| N 767 | 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #73 was assessed by the team leader on 12/18/2013 and no adverse affects were found. Resident #55 was discharged home with Intrepid Home Health on 12/6/2013.
2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:
All residents have the potential to be affected by this practice. Residents are reviewed by the nursing staff daily to ensure a safe, sanitary, and comfortable environment.
3) What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:
Nurse #5, #6, CNA #1, and Licensed nurse were re-educated regarding hand washing, proper handling/serving of food on 12/6/2013 by the nurse educator.
4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur:
Random medication administration audits will be conducted by Director of Nursing, Nurse educator, or designee weekly x's (3) three months to ensure compliance. Pharmacist will assist by re-educating on proper medication administration 12/18/2013 and #10/2013.
Results of audits will be presented to the QAPI Committee by DON or designee for review and analysis times (3) months.
N 767: Continued From page 5

date of purchase... foods purchased refrigerated... Pudding 2 days after opening,...
tuna 1- to 2 days... chicken 1-2 days... deli foods... salads containing meat, fish, poultry or eggs 3-4 days..."

2. Observations in the kitchen on 12/2/13 beginning at 10:50 AM revealed the following expired foods stored in the reach-in refrigerator:

3. Observations in the kitchen on 12/2/13 beginning at 10:50 AM revealed a carbon buildup on four shallow baking pans, two muffin pans, a large pot and a deep baking pan.

4. During the 400 hall dining observations on 12/2/13 beginning 12:45 PM, certified nursing assistant (CNA) #1 held a spoon of pureed green beans up to the light to see if it was hot, then blew on the spoon of pureed green beans before feeding them to the resident. CNA #1 then held another spoon of mashed potatoes up to the light to see if it was hot, then blew on the mashed potatoes before feeding them to the resident.

During an interview in the Director of Nursing's (DON) office on 12/4/13 at 9:00 AM, the DON was asked would she expect her staff to blow on resident's food to cool it off before feeding it to them. The DON stated, "No, that's an infection control issue... they know better than that..."