F 253 483.15(h)(2) HOUSEKEEPING/MAINTENANCE

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 observations, it was determined the facility failed to ensure resident rooms were clean and in good repair as evidenced by the presence of dirty grout, scuffed walls, a sink was slow to drain, dirty floors, trash on the floors, scuffed paint, missing tile, scuffed floors, brown/black buildup around baseboards, a baseboard was missing and dirty caulking around a commode for 9 of 45 (Rooms 101, 113, 114, 115, 116, 117, 120, 122 and 214) resident rooms.

The findings included:
Observations during the initial tour on 12/7/09 beginning at 8:00 AM, revealed the following:
a. Room 101 - The grout around the commode in the bathroom was dirty and the paint was scuffed on the walls.
b. Room 113 - The grout around the commode in the bathroom was dirty and the water in the sink was slow to drain out.
c. Room 114 - The floor in the bedroom was dirty with trash on the floor around the trash can.
d. Room 115 - The paint on the closet was scuffed. The door facing into the room from the bathroom had black marks and paint missing.
e. Room 116 - There was a dark brown substance around the floor at the baseboard entering the bathroom. The tile was missing around the threshold on right entering the bathroom. The floor was scarred with black

Crestview Plan of Correction Survey
12-07-2009

F 253 SS=D Housekeeping/Maintenance

Corrective Action for Resident Cited
Room 101 - The grout around the commode in the restroom and the scuffed paint on the walls will be repaired.
Room 113 - The grout around the commode in the restroom and the slow draining sink will be repaired.
Room 114 - The floor has been cleaned and the trash disposed of properly.
Room 115 - The paint on the closet and on the door facing the room from the bathroom will be repaired.
Room 116 - The floor and baseboards of the bathroom has been cleaned and the floor tiles will be repaired.
Room 117 - The floor and baseboards of the bathroom has been cleaned and the door facing on the left will be repainted.
Room 120 - The floor baseboard will be replaced.
Room 122 - The floors, baseboards, walls, and door knob will all be cleaned. The baseboard will be re-attached to the outer wall in the corner under the left side of the window.
Room 214 - The dirty graduate container has been discarded and the commode has been cleaned and the caulking repaired.
### Identification of Other Residents

All residents have the potential to be affected by this deficient practice. A comprehensive physical plant/resident environment audit will be conducted by the directors of maintenance and environmental services (or their designees) to identify unsanitary conditions and repair needs. The needed cleaning and repairs will be addressed and completed as identified in the audit by 01-09-2010.

### Measure Put in Place or System Changes

The Directors of the Maintenance department and the Housekeeping department will be educated and instructed by the administrator to conduct a monthly comprehensive facility audit to identify areas needing repair or deep cleaning. These audits will be conducted and the needs identified by the audit will be addressed and completed as indicated by 01-09-2010.

In addition, housekeeping personnel will also be educated by 01-09-2010 to identify and document identified needs on a daily basis as they move from room to room carrying out their cleaning assignments and to submit work orders to the maintenance department for identified repairs needed. Repairs will be carried out as indicated. This education will be done by their respective department directors by 01-09-2010.
<table>
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<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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</thead>
</table>
| F 253 | Continued From page 1 | marks.  
  f. Room 117 - There was a brown and black buildup around baseboard, under the sink and around wall behind commode and length of commode under toilet tissue holder in the bathroom. The door facing on the left entering the bathroom was very scarred from the floor up 4 feet on inside of bathroom.  
  g. Room 120 - The baseboard was missing behind the door at the corner when entering the room.  
  h. Room 122 - A black substance was on the baseboard, on the wall and along the door to the outside of building. A brown substance was on the door 2.5 feet under the door knob. There was a space between the baseboard and outer wall in the corner and a space between the baseboard and wall in the corner under the left side of the window.  
  i. Room 214 - The bathroom had a dirty container used to measure output on the floor behind the toilet and a dark brown substance was on the caulking around the bottom of the toilet. | F 253 | Monitoring Corrective Action  
The Directors of the Maintenance and Housekeeping departments will submit monthly comprehensive facility plant audits along with the corrective actions to the Quality Improvement committee on a monthly basis for review. The administrator will be responsible for reviewing these reports. Findings will be analyzed and QI Committee will evaluate the effectiveness of present plan and will recommend revisions as needed.  
QI committee members include but are not limited to Administrator, DON, Medical Director, Medical Records, Social Services, Activities, and Unit managers. |
| F 309 | SS=D | 483.25 QUALITY OF CARE  
Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. | F 309 |  
This REQUIREMENT is not met as evidenced by:  
Based on medical record review, observation and interview, it was determined the facility failed to ensure a resident had physician's orders for |
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<th>F 309: Continued From page 2</th>
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<tr>
<td>dialysis treatments and or ensure medications</td>
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<td>were not given unless ordered by a physician for</td>
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<tr>
<td>1 of 18 (Resident #12) sampled residents and for</td>
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<tr>
<td>Random Resident (RR #1).</td>
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The findings included:

1. Medical record review for Resident #12 documented an admission date of 11/6/09 with diagnoses of Depression, Dementia, Organic Brain Syndrome, Thrombocytopenia, Down's Syndrome, Hypertension and End Stage Renal Disease (ESRD). Review of the physician's progress note dated 11/16/09 documented "...ESRD...continue dialysis..." Review of the current physician's orders dated 10/30/09 had no documentation of an order for dialysis.

Observations in the dining room on 12/8/09 at 3:30 PM, revealed Resident #12 seated in a wheelchair talking with staff and other residents.

During an interview in the Director of Nurses (DON) office on 12/9/09 at 9:50 AM, the DON was asked for an order for the dialysis. The DON stated, "...No, the order is not there. I'll write a clarification order." At 10:10 AM, the DON confirmed "...The dialysis is not mentioned in the physician orders."

2. Medical record review for RR #1 documented an admission date of 9/21/06 with diagnoses of Schizo-affective Schizophrenia and Non-Insulin Dependent Diabetes Mellitus. Review of a physician's telephone order dated 10/26/09 documented, "...D/C [discontinue] Ativan 1 mg [milligram]." Review of the controlled substance record revealed the Ativan 1 mg was signed out as given to RR #1 on 11/1/09 at 7:00 AM, six
**Measure Put in Place or System Changes**

The Nurse admitting the resident, reconciles the physician's orders, making sure all orders for services and treatments are included. Orders are processed appropriately. Physician's orders for all new admissions or readmissions will be reviewed by DON or designee on the shift that the resident was admitted to make sure the physician orders were processed correctly.

The resident's nurse who receives the order to discontinue medications, will note the order by following the discontinue medication procedure: remove medication from M.A.R., remove medication from the med cart. The ADON or DON will either return the medication back to the pharmacy or destroy it per facility policy for pharmacy return or medication destruction.

In-services will be completed with all Nurses by DON or designee (unit manager or ADON) on procedures regarding admission and readmission orders, transcription of those orders, and procedure for discontinuing medication orders. These in-services will be on a 1/1 basis and will be completed by 01/08/2010.

24 Hour chart check is performed nightly by 11-7 shift making sure all orders for the day are processed correctly. 11-7 notifies DON when orders are not processed correctly.

All physician orders for 24 hours are reviewed at the morning meeting for accuracy, follow-through, and completeness.
Monitor Corrective Action

Medical Records (MR) audits all admission and re-admission physician orders for special services to include dialysis orders and other outside treatment orders within 72 hours of admission and re-admission. MR reports audit findings to DON for further review, action, and analysis.

All med carts were audited on 12/08/2009 to check for discontinued or expired meds. Carts will be audited weekly times 4 and then monthly for discontinued and/or expired meds by DON or designee.

DON or designee will do medication administration observations with all nurses to check for accuracy following physicians orders to include the five rights.

All audit results are analyzed by the DON and results are reported monthly to the QI committee for further action as required.

QI committee members include but are not limited to Administrator, DON, Medical Director, Medical Records, Social Services, Activities, and Unit managers.
Continued From page 3

days after the order for ativan had been discontinued.

During an interview at the first floor nurses' station on 12/9/09 at 3:58 PM, the DON confirmed the Ativan had been given without a physician's order.

F 323 SS=D Accidents and supervision

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, observations and interviews, it was determined the facility failed to implement new interventions after falls for 2 of 5 (Residents #7 and #14) sampled residents with multiple falls.

The findings included:

1. Medical record review revealed Resident #7 was admitted to the facility on 5/20/08 with diagnoses of Schizo Affective Disorder, Cellulites and Abscess of leg. Review of Resident #7's computerized nurses' notes documented the following falls:
   a. 11/3/08 at 3:42 PM, "INCIDENT TYPE: slid from chair. CARE PLAN: Chair Alarm and bed alarm to be on at all times and remove w/c [wheelchair] at night from side of bed and place in hallway."
**F 323: Continued From page 4**

b. 11/20/08 at 3:36 AM, "INCIDENT TYPE: found sitting in floor in doorway of room. ACTION: to use call light."

c. 11/30/08 at 4:50 AM, "INCIDENT TYPE: found on the floor. Skin tear, laceration, bruise. Bruise: left forearm, size: 11cm [centimeter] in length .5cm in width. ACTION: New brake assembly applied to w/c on left side of w/c per maintenance."

d. 1/7/09 at 3:47 PM, "INCIDENT TYPE: Bruise Fall, scrape ...New fresh bleeding ...2 small scrapes and bruise under L [left] eye. ACTION: Bed alarm in use. (Intervention already in place.)

e. 2/2/09 at 4:23 PM, "INCIDENT TYPE: fall ...skin tear, bruise ...scrape noted on top of head. Small amount of swelling and bruising noted, small skin tear on right arm and small bruise above right elbow. ACTION: check on resident as ordered and in response to alarms.”

f. 2/5/09 at 7:31 AM, "INCIDENT TYPE: Fall Skin tear...left shoulder. ACTION: replaced bed pad alarm.

g. 2/24/09 at 6:55 AM, "INCIDENT TYPE: laceration above left eye. ACTION: use call light if help is needed."

h. 5/18/09 at 12:35 AM, "INCIDENT TYPE: Fall/Laceration ..." No documentation of an action.

i. 8/20/08 at 6:43 PM, "INCIDENT TYPE: Fall ACTION: Observe resident more closely."

j. 8/27/08 at 3:52 PM, "INCIDENT TYPE: Fall ...Resident noted lying on the floor, stated he did not fall, but laid on floor. ACTION: [Named doctor] returned previous call at 3:32 pm and ordered merry walker for resident.”

k. 11/28/09 at 7:47 PM, "INCIDENT TYPE: Fall ...Resident with approx [approximately]. 7 inch vertical reddened abrasion to right medial back; fresh reddened vertical scrape. CARE PLAN: Measure Put in Place or System Changes

The Nurse completes the incident report when the resident falls and begins the investigation. Based on resident assessment and incident report and preliminary investigative findings, intervention(s) to minimize the risk of falling again are implemented by the nurse. The fall incident is reviewed in the department head morning meeting M-F for discussion and input/recommendations from appropriate disciplines. DON completes the investigation and determines the cause(s) of the fall. Residents who fall are reviewed weekly x 4 weeks in the weekly PAR (patients at risk) meeting. Members include DON unit managers, MDS nurse Social Services Activities and wound care nurse. If interventions are determined to be ineffective revisions are made to the interventions. If no falls, residents are reviewed monthly until incident free and then quarterly with care plan meetings to determine if interventions are remaining effective in minimizing the risk for falls.

Care plans are revised/ updated as appropriate following the implementation of interventions and/or care plan reviews. Care cards are exchanged when there are changes in the interventions so all staff are informed.
F 323  Continued from page 5

Resident to be in low bed with pads on floor on side of bed. Use gait belt when assisting with transfers.

i. 11/29/09 at 4:50 PM, "INCIDENT TYPE: Other. found on floor/abrasion to back resident found on floor at foot of bed. ACTION: Mats intact to either side of low bed."

k. 12/7/09 at 8:37 PM, "INCIDENT TYPE: Fall. CARE PLAN: Remove wc at all times from side of bed and place in hallway. res [resident] thinks w/c is his car and gets up to drive and crawls on floor."

Observations in Resident #7's room on 12/7/09 at 8:10 AM, revealed Resident #7 lying on the floor on his right side, holding his head up from the floor. The resident was whistling. Surveyor asked resident why he was on the floor. The resident stated, "I can't get up." The surveyor got help from a nurse in the hallway. The surveyor asked Resident #7 why he was whistling. Resident #7 stated, "I was trying to get somebody's attention." Further observation revealed the floor mats were propped against the wall.

Observations in Resident #7's room on 12/8/09 at 8:02 AM, revealed Resident #7 in a wheelchair attempting to transfer himself from the wheelchair to his low bed. After locking the wheelchair on the 2nd attempt and going to the floor on his right knee, the resident successfully transferred to the bed. Further observation revealed the mats were propped against the wall.

During an interview at the first floor Nurses' station on 12/8/09 at 2:05 PM, the Director of Nurses (DON) stated, "We are now an alarm free facility. When the alarm goes off, by the time you get to them [residents] they have already fallen."

Monitoring Corrective Action

DON (or ADON or designee) makes sure that the care card exchange, alerting all staff of interventions, was done and interventions are current.

DON reports audits of care plans to QI committee monthly for further analysis and review. QI committee trends falls with trending to include the identification of residents whose interventions are not effective or were not implemented.

DON and administrator review all investigations, making sure they are complete and that interventions were identified and implemented. Results of reviews are reported monthly to the QI committee for analysis and further action if required.

QI committee members include but are not limited to Administrator, DON, Medical Director, Medical Records, Social Services, Activities, and Unit managers.
F 323: Continued From page 6
You can't stop falls from happening. Our goal is to prevent injury."

2. Medical record review for Resident #14 documented an admission date of 11/14/00 with diagnoses of Alzheimer's Disease, Diabetes Mellitus, Incontinence and Epilepsy. Review of Resident #14's computerized nurses' notes documented the following falls:
   a. 11/3/06 at 5:30 to (-) 5:45 PM, "...INCIDENT TYPE: found on floorfall... Pt. [patient] found lying on her back on the floor in room 122... ACTIONS: Initiate 72 hour follow up..." There was no injury documented, nor was there documentation of an investigation or intervention.
   b. 11/24/08 at 5:15 PM, "...INCIDENT TYPE: found on floorfall... Laceration 3/4" [inch]
   Laceration on Palm side of right hand... Abrasion on her R [right] lower arm at the elbow... ACTIONS: Initiate 72 hour follow up... Transfer to ER [emergency room] for evaluation of cut to palm... Investigation... Actions taken to protect resident... observe resident closely..." The care plan dated 10/13/08 documented an intervention to "...monitor closely..."
   c. 12/20/08 at 6:45 AM, "...INCIDENT TYPE: found on floorfall, abrasion... found...on the floor on her face down. Slight abrasion noted around right eye and bridge of nose between eyes. No apparent injury noted in other part of body... ACTIONS: continue to observe Initiate 72 hour follow up... Investigation... [no documented actions taken]..." There were no new interventions documented.
   d. 1/7/09 at 1:49 PM, "...INCIDENT TYPE: fall... resident wandering in room 118 and feet became entangled in telephone cord... no apparent injury... ACTIONS: continue to observe Initiate 72 hour follow up... Investigation... Actions taken to
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDIACID SERVICES**

<table>
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<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<td>445409</td>
<td>A. BUILDING</td>
<td>12/09/2009</td>
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<td></td>
<td>B. WING</td>
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<th>NAME OF PROVIDER OR SUPPLIER</th>
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<tr>
<td>CRESTVIEW HEALTH AND REHABILITATION</td>
<td>2030 25TH AVE N</td>
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<td>NASHVILLE, TN 37208</td>
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| F 323              | Continued From page 7  

  - **protect resident... Resident removed from room and taken to her room for a nap...** "The care plan documented an intervention put in place on 9/25/08 to put resident resident to bed when walking a sleep."  
  - **e. 1/10/09 at 10:06 PM, "...INCIDENT TYPE: found on floor/fall... RESIDENT FOUND ON FLOOR BESIDE BED... no apparent injury... ACTIONS: continue to observe Initiate 72 hour follow up... Investigation... [no documented actions taken]..."** There was no documentation of a new intervention put in place.  
  - **f. 4/17/09 at 1:11 PM, "...INCIDENT TYPE: found on floor/fall... Resident found on floor in front of chair she was previously sitting... no apparent injury... ACTIONS: continue to observe Initiate 72 hour follow up... Investigation... Actions taken to protect resident from further injury... Resident placed in bed..."** The care plan documented an intervention put in place on 9/25/08 to put resident to bed when walking a sleep.  
  - **g. 6/13/09 at 12:40 PM, "...INCIDENT TYPE: found on floor/fall... found resident on floor. Upon entering room noted resident on knees with head down, noted moderate amount of blood on floor by closet. Resident checked noted contusion center of forehead, lacerated, bleeding, laceration of bridge of nose left side, abrasion eyebrow region both eyes. Observation of area indicated resident possibly hit head on the door hinge of closet in room 120... ACTIONS: continue to observe Initiate 72 hour follow up... Investigation... [No documented actions taken]..."** There was no documentation of new interventions put in place.  
  - **h. 6/30/09 at 5:00 PM, "...INCIDENT TYPE: found on floor/fall... Resident Found Sitting on the Floor beside the Bed in 117a... No injury noted... ACTIONS: continue to observe Initiate 72 hour follow up...**
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<td>F 323</td>
<td>Continued From page 8</td>
<td>F 323</td>
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<td>follow up... Investigation... Actions taken to protect the resident... Observed closely... &quot;The care plan dated 10/13/08 documented an intervention to &quot;...monitor closely...&quot;</td>
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<td>i. 8/5/09 at 6:00 PM, &quot;INCIDENT TYPE: found on floor/fall... Found in the Floor in the resident Dining room... Resident has a 3x[by] 2 cm bruise on her Left Shoulder... ACTIONS: continue to observe Initiate 72 hour follow up... Investigation... Actions taken to protect the resident... Observed closely...&quot; The care plan dated 10/13/08 documented an intervention to &quot;...monitor closely...&quot;</td>
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<td>j. 8/11/09 at 2:20 PM, &quot;INCIDENT TYPE: found on floor/fall... resident found on floor in room 121... no apparent injury... ACTIONS: continue to observe Initiate 72 hour follow up... Investigation... [No actions taken documented]...&quot; There was no documentation of new interventions put into place.</td>
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<td>k. 8/27/09 at 6:00 PM, &quot;INCIDENT TYPE: found on floor/fall... Found Lying on the floor of room 111... No apparent injury... ACTIONS: continue to observe Initiate 72 hour follow up... Investigation... Actions taken to protect the resident... Observed closely... Placed to Bed...&quot; The care plan dated 10/13/08 documented an intervention to &quot;...monitor closely...&quot;</td>
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<td>l. 9/14/09 at 5:15 PM, &quot;INCIDENT TYPE: found on floor/fall... Resident Found in the floor in room 109a at the foot of the chair... no apparent injury... ACTIONS: Initiate 72 hour follow up... Investigation... Actions taken to protect resident... Observed closely...&quot; The care plan dated 10/13/08 documented an intervention to &quot;...monitor closely...&quot;</td>
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<td>m. 9/20/09 at 11:20 AM, &quot;INCIDENT TYPE: found on floor/fall... in floor in room #123... no apparent injury... ACTIONS: continue to observe...&quot;</td>
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**F 323** Continued From page 9
  Initiate 72 hour follow up..." There was no documentation of an investigation or interventions put in place.
  o. 11/26/09 at 2:40 PM, "...INCIDENT TYPE: found on floor/fall... Resident found laying on back between two tables... dining room... no apparent injury... ACTIONS: continue to observe Initiate 72 hour follow up..." There was no documentation of an investigation or interventions put in place.

  Observations in Resident #14's room on 12/7/09 at 8:12 AM and on 12/8/09 at 7:45 AM and 2:15 PM, revealed Resident #14 lying in bed with bilateral full side rails up.

  During an interview in the conference room on 12/9/09 at 9:20 AM, the DON was asked about interventions for falls on Resident #14. The DON stated, "...I'm just going to tell you [surveyor], I can't stop [Resident #14] her from falling... unless I tie her down..."

  3. During an interview in the conference room on 12/9/09 at 11:25 AM, the DON was asked if there would be any other documentation of interventions that were put into place after each fall for Resident #7 and #14. The DON stated, "...No, that's all there is..."

**F 332** 483.25(m)(1) MEDICATION ERRORS
  SS=E

  The facility must ensure that it is free of medication error rates of five percent or greater.

  This REQUIREMENT is not met as evidenced by:
  Based on policy review, medical record review,
F 332 Continued From page 10

observation and interview, it was determined the facility had a medication error rate of 10 percent (%). Five (5) errors were made out of 50 opportunities of error, when 3 of 8 (Nurses #1, 2 and 3) nurses made errors involving Random Residents (RR) #2, #3 and #4.

The findings included:

1. Medical record review revealed RR #2 was admitted to the facility on 11/17/2006 with diagnoses of Organic Brain Syndrome, Hypothyroidism and Cachexia. Additional diagnoses after a hospitalization from 11/16/09 to 11/20/09 were possible Aspiration Pneumonia, Gastrointestinal Bleed, Acute Dehydration and Renal Insufficiency. Review of the physician discharge medication orders dated 11/20/09 for RR #2, revealed new orders that included: Tylenol 325 milligrams (mg) oral twice daily, Amoxicillin/K Clavulante 500 mg two times a day (BID) for 7 days, and Fesol (Iron) 325 mg daily.

Review of the facility’s Medication Pass Hours policy for routine medication times documented: Daily medications - 9 AM and BID medications 9 AM/5 PM.

Observations in RR #2’s room on 12/6/09 at 8:50 AM, revealed Nurse #1 administered Amoxicillin/K Clavulante 500 mg (order was for this medication to be given for 7 days starting 11/20/09) to RR #2. RR #2 was not given Tylenol 325 mg or Fesol 325 mg as ordered by the physician. The administration of the Amoxicillin/K Clavulante without a current order resulted in medication error #1. The failure to administer Tylenol and Fesol resulted in medication error #2 and #3.

F 332 SS=E Medication errors

Corrective Action for Resident Cited

The physician was notified of the med errors involving RR#2. The Amoxicillin/K was discontinued and new orders received for Fesol to be given. Physician did not want to reorder the Tyleonol.

Medication for RR#3 was received on 12/09/09. Nurse #3 was educated on route of administration for insulin on 12/9/09 by DON

Identification Other Residents

All residents have the potential to be affected by the deficient practice. All current residents admitted since 10/01/09 were reviewed for accuracy of transcription of admission orders. No further errors were found. When Med cart audits are completed by the DON or designee they will also review any liquid medications to see if they will need to be reordered.

Don or designee is educating ad requiring return demonstration for all nurses on proper administration of insulin.
<table>
<thead>
<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 332</td>
<td>Continued From page 11</td>
<td>During an interview in the conference room on 12/8/09 at 10:45 AM, the Director of Nursing (DON) confirmed the facility failed to reconcile the current physician's orders and the physician discharge medication orders for RR #2.</td>
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<tr>
<td>F 332</td>
<td>Measure Put in Place or System Changes</td>
<td>The nurse who admits the resident to the facility also reconciles the medications to be administered. The nurse reviews the order recommendations from the discharging hospital (reviewing every hospital document), residents' previous medications in the facility (if a readmission) and the attending physician orders. The nurse admitting the resident also notes the orders for follow through.</td>
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<td>2. Medical record review for RR #3 documented an admission date of 2/24/03 with diagnoses of Senile Dementia, Major Depressive Disorder with Psychotic behavior Cerebrovascular Disease, Dysphagia and Hemiplegia. Review of the physicians orders dated 12/09 for RR #3 revealed Megace 400 mg [milligrams] / [per] 10cc [cubic centimeter] by mouth Bid.</td>
<td>All nurses will be in-serviced on medication reconciliation on admission and re-admission and the proper procedure for ordering medications (liquids, topicals, eye or ear drops and PRN medications) by the DON or designee (ADON) by 01/08/2010.</td>
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<td>Review of the ordering and receiving medications from pharmacy policy documented &quot;...2. Reorder medication three to four days in advance of need to assure an adequate supply is on hand.&quot;</td>
<td>In-service will include correct route of administering insulin.</td>
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<td>Observations in RR #3's room on 12/8/09 at 4:50 PM, revealed Nurse #2 did not administer the Megace to RR #3, which resulted in medication error #4.</td>
<td>Medication carts will be audited 2x monthly for 3 months, then monthly to ensure liquid medications were ordered timely.</td>
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<td>During an interview in the 300 hall on 12/8/09 at 4:40 PM, Nurse #2 stated the Megace is not in the drawer. After checking the medication administration record, Nurse #2 stated, &quot;It [Megace] was ordered by the morning nurse today, it will be here tomorrow. I won't be giving it [Megace] today.</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
3. Medical record review for RR #4 documented an admission date of 6/9/2000 with diagnoses of Insulin Dependent type Diabetes Mellitus, Blindness both eyes, Hypertension and Congestive Heart Failure. Review of the physician orders dated 12/09 documented "[Novolin R] Insulin Regular Human 100U [units]/ml [milliliters] solution per sliding scale ...181- [lo] 240 = [amount of insulin to be administered] 7 units... sub-Q [subcutaneous]."

Observations in RR #4's room on 12/8/09 at 5:10 PM, revealed Nurse #3 did a finger stick blood sugar with results of 186, which required 7 units of regular insulin to be administered subcutaneous. Nurse #3 administered 7 units of Regular Insulin in the deltoid muscle of the right arm. The wrong route of administration of the insulin resulted in medication error #5.

During an interview in the 200 hall on 12/8/09 at 5:10 PM, the surveyor asked Nurse #3 how insulin should be administered. Nurse #3 stated "IM [intramuscular]." The surveyor asked Nurse #3 if she was sure of that. Nurse #3 stated, "No, I mean it should be given sub-Q." The surveyor asked Nurse #3 "How did you give it [insulin]?” Nurse #3 stated, “I gave it [insulin] IM.”

483.25(m)(2) MEDICATION ERRORS

The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure insulin was administered by the right route for 1 of 2 random...
**F 333** Continued From page 13  
Residents (RR #4) observed receiving insulin injections.

The findings included:

Medical record review for RR #4 documented an admission date of 6/9/2000 with diagnoses of Insulin Dependent type Diabetes Mellitus, Blindness both eyes, Hypertension and Congestive Heart Failure. Review of the physician orders dated 12/09 documented "Novolin R Insulin Regular Human 100U [units] /ml [milliliter] solution per sliding scale ... 161 [to] 240 [amount of insulin to be administered] 7 units... sub-Q [subcutaneous]."

Observations in RR #4's room on 12/8/09 at 5:10 PM, revealed Nurse #3 did a finger stick blood sugar with results of 186, which required 7 units of regular insulin to be administered subcutaneous. Nurse #3 administered 7 units of Regular Insulin in the deltoid muscle of the right arm. The wrong route of administration of the insulin resulted in a significant medication error.

During an interview in the 200 hall on 12/8/09 at 5:10 PM, the surveyor asked Nurse #3 how insulin should be administered. Nurse #3 stated "IM [intramuscular]." The surveyor asked Nurse #3 if she was sure of that. Nurse #3 stated, "No, I mean it should be given sub-Q." The surveyor asked Nurse #3 "How did you give it [insulin]?'" Nurse #3 stated, "I gave it [insulin] IM." 483.50(b), (d), (e) PHARMACY SERVICES

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**F 431**  
SS=D  
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

---

**F 333**  
SS=D Medication errors  
Corrective Action for Resident Cited  
Nurse #3 was immediately educated on proper administration of insulin., including administration by right route.

Identification Other Residents  
All residents have the potential to be affected by deficient practice. All Nurses will be in-service on medication administration to include the five rights by the DON or designee by 01/08/2010.

Measure Put in Place or System Changes  
Medication administration observation will be completed with all nurses by the DON or designee for residents with insulin orders to ensure proper administration technique by 1/08/2010.

Monitoring Corrective Action  
DON, Unit manager or ADON will make compliance rounds weekly x 4 then two times a month and then monthly to observe for proper administration of insulin. DON will report findings to the QI committee monthly for review and further action as necessary.

QI committee members include but are not limited to Administrator, DON, Medical Director, Medical Records, Social Services, Activities, and Unit managers.
F 431 Continued From page 14
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, 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 observation and interview, it was determined the facility failed to ensure expired medications were removed from 1 of 6 (100 hall medication cart) medication storage areas.

The findings included:

F 431 SS=D Pharmacy Services

Corrective Action for Resident Cited

The expired Ativan was immediately removed from the cart.

Identification Other Residents

All residents have the potential to be affected by the deficient practice.

All med carts were checked on 12/08/09 by DON and shift supervisor for expired medications no other expired medications were found. Discontinued medication reports dating back to 12-07-09 are being used to ensure all discontinued meds have been removed from med cart.

Measure Put in Place or System Changes

In-service training will be completed with all nurses by DON or designee by 01-08-2010 on procedure for discontinuing medications.

All controlled drugs will be removed from the cart by the nurse who receives the DC order for the medication and will be turned into the DON for destruction by the DON and the Pharmacy consultant.

DON prints the "Discontinued Medication Report" from the electronic charting system (ECS) two times per month to validate removal of discontinued medication from the cart.
Monitoring Corrective Action

Med carts will be checked by DON or designee (ADON or Unit manager) weekly times 4 weeks then monthly thereafter for expired meds. Pharmacy consultant will do a random audit of 5 residents on each cart monthly and will report findings to DON. Pharmacy consultant will check all Controlled drugs for expiration dates.

Pharmacy consultant will audit med carts on a monthly basis to check for expired medications. Pharmacy consultant will check all controlled drugs for expiration dates monthly and report findings to DON.

Results of all medication cart audits are reported to the DON who analyses the data and reports to QI committee monthly for any further action if required.

QI committee members include but are not limited to Administrator, DON, Medical Director, Medical Records, Social Services, Activities, and Unit managers.

01-09-2010
F 431
Continued From page 15
Observations of the 100 hall medication cart on 12/8/09 at 3:45 PM, revealed a medication bubble pack of Ativan 1 milligram tablets filled by the pharmacy on 10/14/08, with an expiration date of 10/14/09.

During an interview in the 100 hall on 12/8/09 at 3:50 PM, Nurse #4 stated, "...I'm not sure why that's [expired Ativan] still in there, I guess we just kept counting the medication and not looking at the expiration date."

F 465
483.70(h) OTHER ENVIRONMENTAL CONDITIONS
The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:
Based on observations, it was determined the facility failed to ensure the common areas were clean and in good repair as evidenced by torn upholstery and a missing baseboard in 1 of 2 (Second floor) dining/activity rooms.

The findings included:
Observations in the second floor dining/activity room on 12/8/09 beginning at 8:00 AM revealed the following:
a. The couch arm upholstery was torn exposing the frame.
b. The baseboard was missing along the wall at the glass door entering a patio area.
**Monitoring Corrective Action**

The Directors of the Maintenance and Housekeeping departments will submit monthly comprehensive facility plant audits along with the corrective actions to the Quality Improvement committee on a monthly basis for review. The administrator will be responsible for reviewing these reports. Findings will be analyzed and QI Committee will evaluate the effectiveness of present plan and will recommend revisions as needed.

QI committee members include but are not limited to Administrator, DON, Medical Director, Medical Records, Social Services, Activities, and Unit managers.

01-09-2010
<table>
<thead>
<tr>
<th>N 645</th>
<th>1200-8-6-.06(3)(k) Basic Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>(3)</td>
<td>Infection Control.</td>
</tr>
<tr>
<td>(k)</td>
<td>Space and facilities for housekeeping equipment and supply storage shall be provided in each service area. Storage for bulk supplies and equipment shall be located away from patient care areas. The building shall be kept in good repair, clean, sanitary and safe at all times.</td>
</tr>
<tr>
<td></td>
<td>This Rule is not met as evidenced by:</td>
</tr>
<tr>
<td></td>
<td>Type C Pending Penalty #19</td>
</tr>
<tr>
<td></td>
<td>Tennessee Code Annotated 68-11-804(c)19:</td>
</tr>
<tr>
<td></td>
<td>The nursing home shall be clean, sanitary and in good repair at all times.</td>
</tr>
<tr>
<td></td>
<td>Based on observations, it was determined the facility failed to ensure the environment was clean, sanitary and in good repair as evidenced by the presence of dirty grout, scuffed walls, a sink that was slow to drain, dirty floors, trash on the floors, scuffed paint, missing tile, scuffed floors, brown/black build-up around baseboards, missing baseboards, torn upholstery and dirty caulking around a commode for 9 of 46 (Rooms 101, 113, 114, 115, 116, 117, 120, 122 and 214) resident rooms and the second floor dining/activity room.</td>
</tr>
<tr>
<td></td>
<td>The findings included:</td>
</tr>
<tr>
<td></td>
<td>1. Observations during the initial tour on 12/7/09 beginning at 8:00 AM, revealed the following:</td>
</tr>
<tr>
<td></td>
<td>a. Room 101 - The grout around the commode in the bathroom was dirty and the paint was scuffed on the walls.</td>
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<td></td>
<td>b. Room 113 - The grout around the commode in</td>
</tr>
</tbody>
</table>

### Corrective Action for Resident Cited

**Room 101** - The grout around the commode in the restroom and the scuffed paint on the walls will be repaired.

**Room 113** - The grout around the commode in the restroom and the slow draining sink will be repaired.

**Room 114** - The floor will be cleaned and the trash disposed of properly.

**Room 115** - The paint on the closet and on the door facing the room from the bathroom will be repaired.

**Room 116** - The floor and baseboards of the bathroom will be cleaned and the floor tiles repaired.

**Room 117** - The floor and baseboards of the bathroom will be cleaned and the door facing on the left will be repainted.

**Room 120** - The floor baseboard will be replaced.

**Room 122** - The floors, baseboards, walls, and door knob will all be cleaned. The baseboard will be re-attached to the outer wall in the corner under the left side of the window.

**Room 214** - The dirty Graduate container will be discarded and the commode will be cleaned and the caulking repaired.
N 645 Continued From page 1

the bathroom was dirty and the water in the sink was slow to drain out.
c. Room 114 - The floor in the bedroom was dirty with trash on the floor around the trash can.
d. Room 115 - The paint on the closet was scuffed. The door facing into the room from the bathroom had black marks and paint missing.
e. Room 116 - There was a dark brown substance around the floor at the baseboard entering the bathroom. The tile was missing around the threshold on right entering the bathroom. The floor was scarred with black marks.
f. Room 117 - There was brown and black buildup around the baseboard, under the sink and around wall behind commode and length of commode under toilet tissue holder in the bathroom. The door facing on the left entering the bathroom was very scarred from the floor up 4 feet on inside of bathroom.
g. Room 120 - The baseboard was missing behind the door at the corner when entering the room.
h. Room 122 - A black substance was on the baseboard, on the wall and along the door to the outside of building. A brown substance was on the door 2.5 feet under the door knob. There was a space between the baseboard and outer wall in the corner and a space between the baseboard and wall in the corner under the left side of the window.
i. Room 214 - The bathroom had a dirty container used to measure output on the floor behind the toilet and a dark brown substance was on the caulking around the bottom of the toilet.

2. Observations in the second floor dining/activity room on 12/8/09 beginning at 8:00 AM revealed the following:
a. The couch arm upholstery was torn exposing

Second floor dining room - the couch with the torn upholstery will be removed and replaced and the baseboard that is missing along the wall at the glass door will be replaced.

Identification Other Residents

All residents have the potential to be effected by this deficient practice. A comprehensive physical plant/resident environment audit will be conducted by the directors of maintenance and environmental services (or their designee) to identify unsanitary conditions and repair needs. The needed cleaning and repairs will be addressed and completed as identified in the audit by 01-09-2010.

Measure Put in Place or System Changes

The Directors of the Maintenance department and the Housekeeping department will be educated and instructed by the administrator to conduct a monthly comprehensive facility audit to identify areas needing repair or deep cleaning. These audits will be conducted and the needs identified by the audit will be addressed and completed as indicated by 01-09-2010.

In addition, all facility personnel will also be educated by 01-09-2010 to identify and document identified needs on a daily basis as they move from room to room carrying out their assignments and to submit work orders to the maintenance department for identified repairs needed. Repairs will be carried out as indicated. This education will be done by the Maintenance and/or Environmental Department Directors by 01-09-2010.
N 645 Continued From page 2
the frame.
b. The baseboard was missing along the wall at
the glass door entering a patio area.

Monitoring Corrective Action

The Directors of the Maintenance and
Housekeeping departments will submit monthly
comprehensive facility plant audits along with the
corrective actions to the Quality Improvement
committee on a monthly basis for review. The
administrator will be responsible for reviewing
these reports. Findings will be analyzed and QI
Committee will evaluate the effectiveness of
present plan and will recommend revisions as
needed.

QI committee members include but are not
limited to Administrator, DON, Medical Director,
Medical Records, Social Services, Activities, and
Unit managers.
<table>
<thead>
<tr>
<th>K 025</th>
<th>SS=D</th>
<th>NFPA 101 LIFE SAFETY CODE STANDARD</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</td>
</tr>
</tbody>
</table>

This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the fire barriers as required by National Fire Protection Association (101, 8.3.6.1).

The findings included:

Observations of the north corridor on 12/7/09 at 7:45 AM, revealed a penetration in the corridor/fire wall.

The facility maintenance director verified there was a penetration in the corridor/fire wall.

<table>
<thead>
<tr>
<th>K 027</th>
<th>SS=D</th>
<th>NFPA 101 LIFE SAFETY CODE STANDARD</th>
</tr>
</thead>
</table>
|       |      | Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¼-inch thick solid bonded wood cores. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in

K025 NFPA Life Safety Code Standard

Corrective Action for Resident Cited

The penetration in the corridor fire wall will be repaired.

Identification Other Residents

All residents have the potential to be effected by this deficient practice. A comprehensive physical plant audit will be conducted by the directors of maintenance and environmental services (or their designees) to identify fire wall penetrations and other repair needs. The needed repairs will be addressed and completed as identified in the audit by 01-09-2010.

Measure Put In Place or System Changes

The Directors of the Maintenance department and the Housekeeping department will be educated and instructed by the administrator, to conduct a monthly comprehensive facility audit to identify areas needing repair. These audits will be conducted and the needs identified by the audit will be addressed and completed as indicated by 01-09-2010.

In addition, all facility personnel will also be educated by 01-09-2010 to identify and document identified needs on a daily basis as they move from room to room carrying out their assignments and to submit work orders to the maintenance department for identified repairs needed. Repairs will be carried out as indicated. This education will be done by the Maintenance and/or Environmental Department Directors by 01-09-2010.
K025: NFPA 101 LIFE SAFETY CODE STANDARD

Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the smoke barriers as required by National Fire Protection Association (101, 8.3.6.1).

The findings included:

Observations of the north corridor on 12/7/09 at 7:45 AM, revealed a penetration in the corridor/fire wall.

The facility maintenance director verified there was a penetration in the corridor/fire wall.

K027: NFPA 101 LIFE SAFETY CODE STANDARD

Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in

![Signature](signature)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE

Administrator

12-28-09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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.
## Monitoring Corrective Action

The Directors of the Maintenance and Housekeeping departments will submit monthly comprehensive facility plant audits along with the corrective actions to the Quality Improvement committee on a monthly basis for review. The administrator will be responsible for reviewing these reports. Findings will be analyzed and QI Committee will evaluate the effectiveness of present plan and will recommend revisions as needed.

QI committee members include but are not limited to Administrator, DON, Medical Director, Medical Records, Social Services, Activities, and Unit managers.
K 027 Continued From page 1

accordance with 19.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7

This STANDARD is not met as evidenced by:
Based on observation, it was determined the facility failed to maintain the smoke barrier doors as required by National Fire Protection Association (NFPA) 80, 15.1.3; 101, 3.6.3.1.

The findings included:

Observations in the dining room on 12/7/09 at 9:25 AM, revealed the entry fire doors had penetrations on the meeting edge.

The facility maintenance director verified the entry fire doors had penetrations on the meeting edge.

K 052

SS = D

NFPA 101 LIFE SAFETY CODE STANDARD

A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4

This STANDARD is not met as evidenced by:

K 027 D NFPA Life Safety Code Standard

Corrective Action for Resident Cited

The smoke barrier doors in the first floor dining room have been repaired to assure no penetrations on the meeting edge of the door.

Identification Other Residents

All residents have the potential to be effected by this deficient practice. A comprehensive physical plant audit will be conducted by the directors of maintenance and environmental services (or their designees) to identify unsanitary conditions and repair needs. The needed cleaning and repairs will be addressed and completed as identified in the audit by 01-09-2010.

The above audit will include smoke barrier doors, to assure the absence of penetrations or anything else that may impair proper functioning of the doors.

Measure Put in Place or System Changes

The Directors of the Maintenance department and the Housekeeping department will be educated and instructed by the administrator to conduct a monthly comprehensive facility audit to identify areas needing repair. These audits will be conducted and the needs identified by the audit will be addressed and completed as indicated by 01-09-2010.
The members of the safety committee team will be educated and instructed by the administrator to conduct monthly comprehensive facility fire safety audits to identify areas of concern regarding the health and safety of facility residents and staff. These audits will be conducted monthly and the items identified by the audit will be addressed and remedied as indicated.

In addition, housekeeping personnel will also be educated by 01-09-2010 to identify and document identified needs on a daily basis as they move from room to room carrying out their cleaning assignments and to submit work orders to the maintenance department for identified repairs needed. Repairs will be carried out as indicated. This education will be done by their respective department directors by 01-09-2010.

Monitoring Corrective Action

The Directors of the Maintenance and Housekeeping departments will submit monthly comprehensive facility plant audits along with the corrective actions to the Quality Improvement committee on a monthly basis for review. The administrator will be responsible for reviewing these reports. Findings will be analyzed and the QI Committee will evaluate the effectiveness of present plan and will recommend revisions as needed.

QI committee members include but are not limited to Administrator, DON, Medical Director, Medical Records, Social Services, Activities, and Unit managers.

01-09-2010
K 052 Continued From page 2

Based on observation, it was determined the facility failed to maintain the alarm system as required by National Fire Protection Association (72, 101, 9.8.1.3).

The findings included:

Observations of the north hall on 12/7/09 at approximately 8:00 AM, revealed the second floor fire door next to the north hall had a loose magnetic block holder.

The facility maintenance director verified the second floor fire door next to the north hall had a loose magnetic block holder.

K 067 NFPA 101 LIFE SAFETY CODE STANDARD

Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2

This STANDARD is not met as evidenced by:

Based on observation, it was determined the facility failed to maintain the heating ventilation and the air-conditioning system as required by the National Fire Protection Association (NFPA) 90A; 908-4; 101, 19.5.2.1.

The findings included:

Observations of the second floor shower rooms on 12/7/09 at 11:00 AM, revealed there was no heat supply to the area.

K 052 K052 D NFPA Life Safety Code Standard

Corrective Action for Resident Cited

The loose magnetic block holder located on the second floor fire door next to the north hall has been repaired.

Identification Other Residents

All residents have the potential to be effected by this deficient practice. A comprehensive physical plant audit will be conducted by the directors of maintenance and environmental services (or their designees) to identify repair needs. The needed repairs will be addressed and completed as identified in the audit by 01-09-2010.

Measure Put in Place or System Changes

The Directors of the Maintenance department and the Housekeeping department will be educated and instructed by the administrator to conduct a monthly comprehensive facility audit to identify areas needing repair or deep cleaning. These audits will be conducted and the needs identified by the audit will be addressed and completed as indicated by 01-09-2010.

The members of the safety committee team will be educated and instructed by the administrator to conduct monthly comprehensive facility fire safety audit to identify areas of concern regarding the health and safety of facility residents and staff. These audits will be conducted monthly and the items identified by the audit will be addressed and remedied as indicated.
In addition, all facility personnel will also be educated by 01-09-2010 to identify and document identified repair needs on a daily basis as they move from room to room carrying out their assignments and to submit work orders to the maintenance department for identified repairs needed. Repairs will be carried out as indicated. This education will be done by the Maintenance and/or Environmental Department Directors by 01-09-2010.

Monitoring Corrective Action

The Directors of the Maintenance and Housekeeping departments will submit monthly comprehensive facility plant audits along with the corrective actions to the Quality Improvement committee on a monthly basis for review. The administrator will be responsible for reviewing these reports. Findings will be analyzed and QI Committee will evaluate the effectiveness of present plan and will recommend revisions as needed.

QI committee members include but are not limited to Administrator, DON, Medical Director, Medical Records, Social Services, Activities, and Unit managers.

01-09-2010
K 052

Based on observation, it was determined the facility failed to maintain the alarm system as required by National Fire Protection Association (72; 101, 9.8.1.3).

The findings included:

Observations of the north hall on 12/7/09 at approximately 8:00 AM, revealed the second floor fire door next to the north hall had a loose magnetic block holder.

The facility maintenance director verified the second floor fire door next to the north hall had a loose magnetic block holder.

K 057

NFPA 101 LIFE SAFETY CODE STANDARD

Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer’s specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2

This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the heating ventilation and the air-conditioning system as required by the National Fire Protection Association (NFPA) 90A; 908-4; 101, 19.5.2.1.

The findings included:

Observations of the second floor shower rooms on 12/7/09 at 11:00 AM, revealed there was no heat supply to the area.

K 067 D NFPA Life Safety Code Standard

Corrective Action for Resident Cited

The thermostat controls for the second floor shower room were located and the controls were switched from cooling to heat. The shower room was heated.

Identification Other Residents

All residents have the potential to be effected by this deficient practice. The facility’s four shower rooms will be audited by the Maintenance Director or designee weekly to identify any inappropriate temperatures or repair needs for the heating and air conditioning units. Any needed repairs will be completed.

The facility residents will be asked by the Social Services Director and/or the Activity Director if the shower room temperatures are comfortable during monthly resident council meetings. The information gathered will be used when adjusting room temperatures to assure a comfortable bathing/showering atmosphere.

Measure Put in Place or System Changes

The Director of the Maintenance department will audit the facility at the changing of the seasons (the first week of March, June, Sept, Dec) to assure that all air conditioning units have been switched to heat or Air conditioning as appropriate to maintain a comfortable temperature both in the shower rooms and the entire facility.
The facility's four shower rooms will be audited by the Maintenance Director or designee weekly to identify any inappropriate temperatures or repair needs for the heating and air conditioning units. Any needed repairs will be completed.

In addition, housekeeping personnel will also be educated by their department directors to identify and document identified needs (including any temperatures that may be inappropriate) on a daily basis as they move from room to room carrying out their cleaning assignments and to submit work orders or relay information to the maintenance department for identified repairs needed or inappropriate temperatures. Repairs or temperature adjustments will be carried out as indicated.

Monitoring Corrective Action

The Director of Maintenance will submit a comprehensive facility plant audit (including shower room temperatures) along with the corrective actions to the Quality Improvement committee on a monthly basis for review. The administrator will be responsible for reviewing these reports. Findings will be analyzed and QI Committee will evaluate the effectiveness of present plan and will recommend revisions as needed.

QI committee members include but are not limited to Administrator, DON, Medical Director, Medical Records, Social Services, Activities, and Unit managers.
<table>
<thead>
<tr>
<th>K057</th>
<th>Continued From page 3</th>
<th>K067</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The facility maintenance director verified there was no heat supply to the second floor shower room.</td>
<td></td>
</tr>
<tr>
<td>K104</td>
<td><strong>NFPA 101 LIFE SAFETY CODE STANDARD</strong></td>
<td></td>
</tr>
<tr>
<td>SS=D</td>
<td>Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the fire barriers as required by National Fire Protection Association (101, 8.3.6.1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The findings included:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Observations of the second floor janitor / manager's office on 12/7/09 at 7:55 AM, revealed there was a penetration around the vertical shaft in the concrete floor.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Observations of the laundry room area on 12/7/09 at 10:15 AM, revealed a penetration around an exhaust duct.</td>
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<td></td>
<td>3. Observations of the mechanical room on 12/7/09 at 10:20 AM, revealed a penetration around the sprinkler supply pipe.</td>
<td></td>
</tr>
<tr>
<td>K130</td>
<td><strong>NFPA 101 MISCELLANEOUS</strong></td>
<td></td>
</tr>
<tr>
<td>SS=D</td>
<td>OTHER LSC DEFICIENCY NOT ON 2786</td>
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<td>The facility maintenance director verified the deficiencies as noted above.</td>
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<td><strong>K104 D NFPA Life Safety Code Standard</strong></td>
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<td><strong>Corrective Action for Resident Cited</strong></td>
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<td>Second floor janitor's closet – The penetration in the concrete floor around the vertical shaft will be repaired.</td>
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<td>The penetration around the exhaust duct in the laundry room area will be repaired.</td>
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<td>The penetration around the sprinkler pipe in the mechanical room will be repaired.</td>
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<td><strong>Identification Other Residents</strong></td>
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<td>All residents have the potential to be effected by this deficient practice. A comprehensive physical plant audit will be conducted by the directors of maintenance and environmental services (or their designees) to identify repair needs. The needed repairs will be addressed and completed as identified in the audit by 01-09-2010.</td>
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<td><strong>Measure Put in Place or System Changes</strong></td>
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<td>The Directors of the Maintenance department and the Housekeeping department will be educated and instructed by the administrator to conduct a monthly comprehensive facility audit to identify areas needing repair. These audits will be conducted and the needs identified by the audit will be addressed and completed as indicated by 01-09-2010.</td>
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</table>
The members of the safety committee team will be educated and instructed by the administrator to conduct a monthly comprehensive facility fire safety audit to identify areas of concern regarding the health and safety of facility residents and staff. These audits will be conducted monthly and the items identified by the audit will be addressed and remedied as indicated.

In addition, all facility personnel will also be educated by 01-09-2010 to identify and document identified repair needs on a daily basis as they move from room to room carrying out their assignments and to submit work orders to the maintenance department for identified repairs needed. Repairs will be carried out as indicated. This education will be done by the Maintenance and/or Environmental Department Directors by 01-09-2010.

Monitoring Corrective Action

The Directors of the Maintenance and Housekeeping departments will submit monthly comprehensive facility plant audits along with the corrective actions to the Quality Improvement committee on a monthly basis for review. The administrator will be responsible for reviewing these reports. Findings will be analyzed and QI Committee will evaluate the effectiveness of present plan and will recommend revisions as needed.

QI committee members include but are not limited to Administrator, DON, Medical Director, Medical Records, Social Services, Activities, and Unit managers.

01-09-2010
K 130 Continued From page 4

This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the pressurized cylinders as required by National Fire Protection Association 55.6.6.

The findings included:

Observations of the first floor oxygen storage area on 12/7/09 at 8:40 AM, revealed an oxygen cylinder was not chained or supported from falling.

The facility maintenance director verified an oxygen cylinder was not chained or supported from falling.

K 147 NFPA 101 LIFE SAFETY CODE STANDARD

Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the electrical system as required by National Fire Protection Association (NFPA) 70, 110-13(a); 70, 240-4; 70, 210-8(a)(6).

The findings included:

1. Observations of the second floor janitor room on 12/7/09 at 7:50 AM, revealed the panel had a loose front cover.

2. Observations in the 200 hall assisted shower


The pressurized Oxygen tanks in the first floor oxygen storage room have been secured/supported to prevent the tanks from falling.

Identification Other Residents

All residents have the potential to be effected by this deficient practice. The physical plant (with focus on Oxygen storage areas) will be audited by safety committee members to identify this and any other areas of concern regarding the health and safety of the residents and staff. This audit will be completed by 01-09-2010.

Measure Put in Place or System Changes

The members of the safety committee team will be educated and instructed by the administrator to conduct monthly comprehensive facility safety audit to identify areas of concern regarding the health and safety of facility residents and staff (with emphasis on Oxygen storage areas). These audits will be conducted monthly and the items identified by the audit will be addressed and remedied as indicated.

In addition, all facility personnel will also be educated by 01-09-2010 to identify areas of concern in regards to health and safety on a daily basis as they move from room to room carrying out their assignments and to submit this information to the Safety committee/maintenance department for repair/remedy of identified concerns. Remedies will be carried out as indicated. This education will be done by the Maintenance and/or Environmental Department Directors by 01-09-2010.
Monitoring Corrective Action

The Chairperson of the Safety Committee will submit the results of the monthly facility safety audits along with the corrective actions to the Quality Improvement committee on a monthly basis for review. The administrator will be responsible for reviewing these reports. Findings will be analyzed and QI Committee will evaluate the effectiveness of present plan and will recommend revisions as needed.

QI committee members include but are not limited to Administrator, DON, Medical Director, Medical Records, Social Services, Activities, and Unit managers.
K 130 Continued From page 4

This STANDARD is not met as evidenced by:
Based on observation, it was determined the facility failed to maintain the pressurized cylinders as required by National Fire Protection Association 55, 6.6.

The findings included:

Observations of the first floor oxygen storage area on 12/7/09 at 8:40 AM, revealed an oxygen cylinder was not chained or supported from falling.

The facility maintenance director verified an oxygen cylinder was not chained or supported from falling.

K 147 NFPA 101 LIFE SAFETY CODE STANDARD

Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

This STANDARD is not met as evidenced by:
Based on observation, it was determined the facility failed to maintain the electrical system as required by National Fire Protection Association (NFPA) 70, 110-13(a); 70, 240-4; 70, 210-8(a)(6).

The findings included:

1. Observations of the second floor janitor room on 12/7/09 at 7:50 AM, revealed the panel had a loose front cover.
2. Observations in the 200 hall assisted shower

K 147 D NFPA Life Safety Code Standard

Corrective Action for Resident Cited

The electrical panel cover in the second floor janitor closet has been tightened.

A cover plate has been installed on the switch outlet in the 200 hall assisted shower room on the east side.

All electrical outlets in the Dietary area have been replaced with Ground Fault Circuit Interrupter receptacles.

The extension cord that was in use in the dining room has been removed.

Identification Other Residents

All residents have the potential to be effected by this deficient practice. A comprehensive physical plant audit will be conducted by the directors of maintenance and environmental services (or their designees) to identify repair needs (with emphasis on electrical wiring). The needed repairs will be addressed and completed as identified in the audit by 01-09-2010.

The members of the safety committee team will be educated and instructed by the administrator to conduct monthly comprehensive facility fire/safety audit to identify areas of concern regarding the health and safety of facility residents and staff (emphasis on electrical wiring). These audits will be conducted monthly and the items identified by the audit will be addressed and remedied as indicated.
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<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-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X6) COMPLETE DATE</th>
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<td>The Directors of the Maintenance department and the Housekeeping department will be educated and instructed by the administrator to conduct a monthly comprehensive facility audit to identify areas needing repair. These audits will be conducted and the needs identified by the audit will be addressed and completed as indicated by 01-09-2010. In addition, all facility personnel will also be educated by 01-09-2010 to identify areas of concern (emphasis on electrical wiring) in regards to health and safety on a daily basis as they move from room to room carrying out their assignments and to submit this information to the Safety committee/maintenance department for repair/remedy of identified concerns. Remedies will be carried out as indicated. This education will be done by the Maintenance and/or Environmental Department Directors by 01-09-2010.</td>
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<td><strong>Continued From page</strong></td>
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<tr>
<td>K 147</td>
<td>Continued From page 5 room on the east-side on 12/7/09 at 8:30 AM, revealed a switch outlet without a cover plate. 3. Observations in the dietary area on 12/7/09 at 9:45 AM, revealed there were a total of six electric outlets which were not on Ground Fault Circuit Interrupter. NFPA 70, 210-8(a)(6). 4. Observations in the dining room on 12/7/09 at 9:60 AM, revealed the use of an extension cord. NFPA 70, 240-4. The facility maintenance director verified the deficiencies as noted above.</td>
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<tr>
<td>K 147</td>
<td>Monitoring Corrective Action The Directors of the Maintenance and Housekeeping departments and the Safety Committee Chairperson will submit monthly comprehensive facility plant audits along with the corrective actions to the Quality Improvement committee on a monthly basis for review. The administrator will be responsible for reviewing these reports. Findings will be analyzed and QI Committee will evaluate the effectiveness of present plan and will recommend revisions as needed. QI committee members include but are not limited to Administrator, DON, Medical Director, Medical Records, Social Services, Activities, and Unit managers. 01-09-2010</td>
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N 832 Building Standards

Corrective Action for Resident Cited

1. The items A, B, and C are related and will be addressed together. The remedies for these items will be more involved as the foundation of the facility may be in question. After speaking to the member of the survey team who conducted our life safety portion (Mr. Seth M. Afoley / Fire Safety Specialist) it became apparent that a professional consultation would be necessary.

Two separate Structural Engineering firms have been contacted to provide us with an analysis of the structural disposition of the building (Logan Patri Engineering, and Charles McCann and Associates). Their inspections of the foundation and the effects as cited in the survey will be completed before 01-09-2010. The remedy to follow will be based upon their findings and recommendations to us. The final completion date of this remedy is not able to be determined at this time. However we intend to keep the State Survey Office appraised of our progress as things develop.

I would also respectfully request a Desk review of this tag.

2. The missing escutcheon plate next to the shower head on the second floor shower room will be replaced.

3. The rotten window trim around the through the wall heating unit will be repaired.

4. The west and north walls of the business office will be repaired and repainted.
Monitoring Corrective Action

The Directors of the Maintenance and Housekeeping departments will submit monthly comprehensive facility plant audits along with the corrective actions to the Quality Improvement committee on a monthly basis for review. The administrator will be responsible for reviewing these reports. Findings will be analyzed and QI Committee will evaluate the effectiveness of present plan and will recommend revisions as needed.

QI committee members include but are not limited to Administrator, DON, Medical Director, Medical Records, Social Services, Activities, and Unit managers.

01-09-2010
N 832 Continued From page 1

The facility maintenance director verified the deficiencies as noted above.

N 901 1200-8-6-09(1) Life Safety

1. Any nursing home which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.

This Rule is not met as evidenced by:
Based on observation and manual testing, it was determined the facility failed to maintain the overall nursing home environment as required by the Tennessee Department of Health (TDOH).

The findings included:

1. Observations on 12/7/09 at 7:58 AM, revealed the night lights in rooms 101, 209 and 221 were burnt out when manually tested. TDOH 1200-08-08-08, National Fire Protection Association (NFPA) 101, 7.9.2.2.

2. Observations on 12/7/09 at 8:05 AM, revealed the bathroom door frames in resident rooms 205, 206 and 207 were rotten at the base and also loose from the wall. TDOH 1200-08-08-08.

The facility maintenance director verified the deficiencies as noted above.

N 901 Life Safety

Corrective Action for Resident Cited
1. The night lights in rooms 101, 209 and 221 have been repaired and are functional.

2. The bathroom door frames in resident rooms 205, 206 and 207 have been repaired.

Identification Other Residents
All residents have the potential to be effected by this deficient practice. A comprehensive physical plant audit will be conducted by the directors of maintenance and environmental services (or their designees) to identify repair needs. The needed cleaning and repairs will be addressed and completed as identified in the audit by 01-09-2010.

Measure Put in Place or System Changes
The Directors of the Maintenance department and the Housekeeping department will be educated and instructed by the administrator to conduct a monthly comprehensive facility audit to identify areas needing repair or deep cleaning. These audits will be conducted and the needs identified by the audit will be addressed and completed as indicated by 01-09-2010.

In addition, housekeeping personnel will also be educated by 01-09-2010 to identify and document identified needs on a daily basis as they move from room to room carrying out their cleaning assignments and to submit work orders to the maintenance department for identified repairs needed. Repairs will be carried out as indicated. This education will be done by their respective department directors by 01-09-2010.
Monitoring Corrective Action

The Directors of the Maintenance and Housekeeping departments will submit monthly comprehensive facility plant audits along with the corrective actions to the Quality Improvement committee on a monthly basis for review. The administrator will be responsible for reviewing these reports. Findings will be analyzed and QI Committee will evaluate the effectiveness of present plan and will recommend revisions as needed.

QI committee members include but are not limited to Administrator, DON, Medical Director, Medical Records, Social Services, Activities, and Unit managers.

01-09-2010
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Measure Put in Place or System Changes

The Directors of the Maintenance department and the Housekeeping department will be educated and instructed by the administrator to conduct a monthly comprehensive facility audit to identify areas needing repairs. These audits will be conducted and the needs identified by the audit will be addressed and completed as indicated by 01-09-2010.

In addition, housekeeping personnel will also be educated by 01-09-2010 to identify and document identified needs on a daily basis as they move from room to room carrying out their cleaning assignments and to submit work orders to the maintenance department for identified repairs needed. Repairs will be carried out as indicated. This education will be done by their respective department directors by 01-09-2010.