**F 164** PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law, third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined the facility failed to ensure 2 of 8 (Nurse #9 and #10) nurses, observed administering medications, maintained a resident's full visual privacy by not closing the

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**LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

**FORM CMS-2557(02-99) Previous Versions Obsolete**

**Event ID:** 703411  
**Facility ID:** TN1831  
**If continuation sheet Page 1 of 27**
F 164  Continued From page 1
Medication Administration Record (MAR) or by exposing a resident by not closing the door of the resident’s room when administering an injection.

The findings included:

1. Observations on the 2nd floor east hall on 5/2/11 at 4:50 PM, Nurse #9 left the MAR open on top of the medication cart, with a resident’s health information visible to anyone who passed by.

During an interview in the Unit Manager’s office on 5/3/11 at 2:55 PM, Nurse #11 confirmed "...they [nurses] usually put a page over the name [on MAR]..."

2. Observations on the 2nd floor south hall on 5/3/11 at 5:15 PM, Nurse #10 administered an insulin injection into a resident’s abdomen with the resident sitting in the doorway of her room facing the hallway. The resident’s abdomen was exposed to anyone who passed by.

During an Interview in the Unit Manager’s office on 5/3/11 at 2:55 PM, Nurse #11 confirmed "...they [nurses] should go back into the room, shut the door or curtain so they [residents] are not seen by other residents or visitors [when receiving an injection in their abdomen]..."

F 309  HIGHEST WELL BEING

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.

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<thead>
<tr>
<th>ID</th>
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<td>F 164</td>
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<td>F 309</td>
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This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation and interview, it was determined the facility failed to follow physician’s orders for wound care, elevation of extremities, floating heels, bowel movement (BM) protocol, cordless call light or chair alarm for 6 of 17 (Residents #2, 3, 6, 12, 13 and 14) sampled residents.

The findings included:

1. Medical record review for Resident #2 documented an admission date of 6/8/10 with readmission date of 4/1/11 with diagnosis of Pneumonia and Wounds on Bilateral Heals. Review of a physician’s order dated 4/1/11 documented, “...Elevate right hand Q [every] shift...”

Observations in Resident #2’s room on 5/3/11 at 7:30 AM, 9:20 AM, 9:50 AM and 10:25 AM and on 5/4/11 at 1:20 PM and 2:25 PM, revealed Resident #2’s right hand was not elevated as ordered.

During an interview in Resident #2’s room on 5/4/11 at 3:30 PM, Nurse #5 confirmed that the resident’s right hand was not elevated.

### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/Clinical Laboratory Improvement Amendments (CLIA) Identification Number:** 445203

**Date Survey Completed:** 05/04/2011

**Name of Provider or Supplier:** West Meade Place

**Address:** 1000 St. Luke Drive
Nashville, TN 37205

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID Tag</th>
<th>Description</th>
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| F 309  | Continued From page 3 wrap c kerlix. Change daily and PRN as needed..." Review of a physician's order dated 4/18/11 documented, "...Order Description: L [left] heel and lateral foot: Clean c NS/WC, apply mepilex heel cover c kerlix and PRN until healed..."

Observations in Resident #2's room on 5/3/11 at 10:25 AM, revealed Nurse #2 (treatment nurse) assisted Nurse #3 (wound care specialist) with a dressing change on Resident #2. Nurse #3 wiped the arterial wounds on Resident #2's right heel, left heel and toes with betadine swabs then applied dressings. Nurse #3 did not follow the physician's orders for cleaning the wound with NS/WC, apply mepilex heel cover with kerlix.

During an interview on the 3rd floor on 5/3/11 at 11:40 AM, when surveyor asked Nurse #2 if Nurse #3 changed the orders before the physician is contacted. Nurse #2 stated, "I will call and get the treatment changed today. Normally we call him [physician] first."

During an interview outside the conference room on 5/4/11 at 10:15 AM, the Director of Nursing (DON) confirmed that Nurse #3 should abide by the facility's policy and procedures.

2. Medical record review for Resident #3 documented an admission date of 4/16/10 with diagnoses of Osteoporosis, Hypertension and Hypopotassemia. Review of a physician's order dated 3/4/11 documented, "...Bilateral heels to be floated at all times while in bed..."

Observations in Resident #3's room on 5/2/11 at 10:50 AM, 3:30 PM and 5:20 PM, on 5/3/11 at...
<table>
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<th>F 309</th>
<th>Continued From page 4</th>
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<tr>
<td>7:40 AM, 9:25 AM and 11:30 AM and on 5/4/11 at 9:25 AM, revealed Resident #3 lying in bed with her heels not floated as ordered.</td>
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<td>During an interview in Resident #3's room on 5/4/11 at 9:20 AM, Nurse #5 verified that Resident #3's heels were not floating.</td>
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<td>3. Review of the facility's &quot;Bowel Protocol&quot; policy documented, &quot;Every nurse should review all BM tracking daily to Insure completion by CNTs [certified nursing technicians]. Initiating the following TX [treatment] for residents who have not had a significant Bowel Movement in six shifts or two days will be done by the 7a [AM] to 7p [PM] charge nurse, with administration of laxatives to be given at bedtime (HS)....&quot;</td>
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<td>Medical record review for Resident #6 documented an admission date of 9/2/98 with a readmission date of 8/5/06 with diagnoses of Multiple Sclerosis, Paraplegia, Diabetes Mellitus, Neurogenic Bladder, Osteoporosis, Peripheral Vascular Disease and Constipation. Review of Resident #6's &quot;Vitals Report&quot; had no BMs documented for Resident #6 from 11/1/10 through (-) 11/17/10, from 11/25/10-11/30/10, from 1/6/11-1/11/11, from 3/10/11-3/15/11 and from 4/2/11-4/7/11.</td>
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<td>During an interview at the 3rd floor nurses' station on 5/4/11 at 1:45 PM, Nurse #7 stated, &quot;...we will have to fix that [ensure the bowel protocol is followed]....&quot;</td>
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<td>4. Medical record review for Resident #12 documented an admission date of 10/10/01 and a readmission date of 11/8/06 with diagnoses of</td>
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### Continued From page 5


During an interview in the conference room on 5/4/11 at 9:05 AM, Nurse #7 was asked about Resident #12 not having laxative interventions after no bowel movements in 3 days. Nurse #7 confirmed there should have been interventions put in place. Nurse #7 stated, "It [bowel protocol] needs work."

Review of the physician's orders dated 3/29/11 documented, "...Chair alarm to enable resident to be OOB [out of bed] ...Cordless Call Light in place..."

Observations in Resident #12's room on 5/2/11 at 4:30 PM, on 5/3/11 at 8:15 AM and on 5/4/11 at 8:10 AM, revealed no chair alarm in place as ordered.

During an interview in Resident #12's room on 5/4/11 at 8:10 AM, Nurse #6 was asked about the chair alarm. Nurse #6 stated, "No, she [Resident #12] doesn't have one."
F 309  Continued From page 8

Observations in Resident #12's room on 5/2/11 at 4:30 PM, on 5/3/11 at 2:30 PM and on 5/4/11 at 7:56 AM, revealed no cordless call light as ordered.

During an interview in Resident #12's room on 5/4/11 at 8:10 AM, Nurse #6 was asked about the cordless call light. Nurse #6 stated, "I'm not sure what that [cordless call light] is."

During an interview in Resident #12's room on 5/4/11 at 9:45 AM, Nurse #7 was asked about the cordless call light. Nurse #7 confirmed there was no cordless call light.

During an interview in Resident #12's room on 5/4/11 at 9:46 AM, Resident #12 stated, "I haven't had it [cordless call light] in a long time."

5. Medical record review for Resident #13 documented an admission date of 7/24/10 with diagnoses of Osteoporosis, Dementia, Urinary Retention and Depression. Review of a physician's order dated 1/11/11 documented, "...Bilateral heels must be floated at all times while in bed."

Observations in Resident #13's room on 5/2/11 at 10:40 AM and on 5/4/11 at 7:40 AM, 8:35 AM and 9:15 AM, revealed Resident #13 lying in bed, with his heels not floated as ordered.

During an interview in Resident #13's room on 5/4/11 at 9:16 AM, Nurse #5 verified that Resident #13's heels were not floated.

6. Review of the facility's "Dressing - Non-Sterile" policy documented, "...15. Clean wound with
<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>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 7 prescribed solution with 4 x [by] 4 gauze pads...&quot;</td>
<td>F 309</td>
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<td>Medical record review for Resident #14 documented an admission date of 2/15/11 with diagnoses of Fracture of Vertebrae, Malaise and Fatigue, Difficulty Walking and Ulcers on Bilateral Heels. Review of a physicians order dated 4/6/11 documented, &quot;...Clean bilateral heels c [with] NS [normal saline]/WC [wound cleaner], apply santyl, cover c mepilex heel and secure c tubigrip or kerlix. Change daily...&quot;</td>
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<td>Observations in Resident #14's room on 5/3/11 at 2:45 PM. Nurse #2 did wound care on Resident #14. Nurse #2 sprayed Resident #14's right heel with wound cleaner then the left heel. Both heels were placed on a large towel that was already under the resident's feet. Nurse #2 then applied the santyl to each heel and Mepilex heel dressing and secured with kerlix and tape. Nurse #2 failed to clean the wounds before applying the santyl or applying new dressings.</td>
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<tr>
<td>F 314</td>
<td>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</td>
<td>F 314</td>
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<td>SS=G</td>
<td>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>1. Immediate and corrective action took place on 5/5/11. It was confirmed through observation on 5/5/11, per nurse monitor that Resident #4 had heel protectors on while in bed and that Resident #17 had a weekly skin assessment completed per the charge nurse and a completed shower sheet per the charge nurse and C.N.T. All facility nursing staff (nurses and C.N.T.s) were in-service per the DON/NEC on pressure ulcer prevention and treatment; and on skin assessment procedures on 5/5/11 and 5/10/11.</td>
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### F 314 Continued From page 8

Based on the "National Pressure Advisory Panel [NPUAP] Pressure Ulcer Prevention QUICK REFERENCE GUIDE", policy review, medical record review, observation and interview, it was determined the facility failed to prevent, identify and treat a pressure ulcer for 2 of 5 (Residents #4 and 17) sampled residents with pressure ulcers. The failure to identify and prevent skin breakdown prior to the development of a Stage 3 pressure ulcer resulted in actual harm to Resident #17.

The findings included:

1. Review of the "National Pressure Advisory Panel Pressure Ulcer Prevention QUICK REFERENCE GUIDE" documented, "...p. 8...Category Stage III: Full thickness skin loss Full thickness tissue loss...slough may be present... p. 12... 3. inspect skin regularly for signs of redness... Ongoing assessment of the skin is necessary to detect early signs of pressure damage. 4. Skin inspection should include assessment for localized heat, edema, or induration (hardness)..."

2. Review of the facility's "SKIN ASSESSMENTS" policy documented, "Every floor nurse on 7a- [to] 7p has daily skin assessments that must be complete... For any skin problems the floor nurses are required to write an order and initiate bx [treatment]..."

3. Medical record review for Resident #17 documented an admission date of 3/1/10 and a readmission date of 4/19/11 with diagnoses of Left Distal Femur Fracture, Severe Osteoporosis, Dementia, Coronary Artery Disease, Spinal...
<table>
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<th>F 314 Continued From page 9</th>
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| Stenosis, Hypertension, Benign Prostatic Hypertrophy, Peripheral Artery Disease and Anemia. Review of the Weekly Skin Assessment sheet completed by the Certified Nursing Assistant (CNA) dated 4/21/11 documented, "blist" with a line pointing to the back of the left leg. Review of the "Progress Note" dated 4/25/11 at 3:12 PM documented, "Stage 3 noted to posterior calf area beneath brace, wound including redness surrounding wound measures approx [approximately] 4.5 cm [centimeters] x [by] 4.5 cm..." Review of the "NURSES DAILY SKILLED NOTES" dated 4/19/11 through 4/25/11 documented, "...SKIN ...Skin Color normal...". Review of the computerized "NURSES DAILY SKILLED NOTES" dated 4/26/11 documented, "...SKIN ...Skin Color normal... Decubitus Wound...". Review of the care plan dated 4/12/11 documented, "...APPROACH: Cn-going monitoring for signs / [and] sx [symptoms] of skin breakdown. Skin assessment and Braden scale per policy and pm [as needed]...".

Observations in Resident #17's room on 5/4/11 at 8:50 AM, revealed Resident #17 lying in bed on his back. Inspection of the wound to his left calf revealed, eschar with redness around the wound.

During an interview in Resident #17's room on 5/4/11 at 8:50 AM, Nurse #2 was asked when Resident #17 developed the wound and what stage it was at that time. Nurse #2 stated, "...April 25th [date wound was found]...it was Stage 3 due to slough in the wound bed...".

During an interview in the 2nd floor Unit Manager's office on 5/4/11 at 1:13 PM, Nurse #11 was asked how often she expected skin
**F 314** Continued From page 10

assessments to be done on residents. Nurse #11 stated, "...every other day with shower... by the CNT [Certified Nursing Technician]..." When asked how often she expected the nurses to perform a skin assessment. Nurse #11 stated, "...daily as they're providing care...""

During an interview at the 2nd floor nurses' station on 5/4/11 at 1:35 PM, CNA #14 was asked how often skin assessments are done by CNAs. CNA #14 stated, "...every shower day... and we give these [weekly skin assessment sheets] to the nurse..." CNA #14 was asked if she had noted any skin breakdown for Resident #17 on 4/25/11. CNA #14 stated, "...No, I was off for about 5 days and when I came back I heard some of the others talking about it [skin breakdown]..."

During an interview at the second floor nurses' station on 5/4/11 at 1:42 PM, CNA #12 was asked if she had noted any skin breakdown for Resident #17 on 4/25/11. CNA #12 stated, "...a few days before I had seen a little blister on his leg..."

During an interview in the Director of Nursing's office on 5/4/11 at 2:15 PM, Nurse #2 was asked when there was any indication of skin breakdown and when treatment was started for Resident #17. Nurse #2 presented the weekly skin assessment sheets completed by the CNAs at bath time and stated, "...No one [nurse] signed this sheet [weekly skin assessment sheet dated 4/21/11]... guarantee this CNT told someone... We don't have a skin assessment for 4/19 or 4/23... No treatment was started at this time..." Nurse #2 stated the "...Weekend Supervisor..."
Continued From page 11

treated it [the Stage 3 breakdown] on April 25th..." and that Nurse #2 saw Resident #17 on 4/26/11 and "...slough was present."

The failure to identify and prevent skin breakdown prior to the development of a Stage 3 pressure ulcer resulted in actual harm to Resident #17.

4. Medical record review for Resident #4 documented an admission date of 3/22/11 with diagnoses of Urinary Tract Infection, Right Heel Stage II Pressure Sore, Malaise and Fatigue, Klebsiella Pneumonia, Atrial Fibrillation, Atrial Flutter Cerebrovascular Accident and Dysphagia. Review of the physician's order dated 4/4/11 documented, "...Heel Protectors on When in Bed Special Instructions: Check twice daily to ensure that the heel protectors are on when in bed..."

Observations in Resident #4's room on 5/3/11 at 9:00 AM, Nurse #5 was asked to check Resident #4's drawers and closets for the heel protectors. Nurse #5 was unable to locate heel protectors in Resident #4's room.

During an interview in the second floor hallway on 5/3/11 at 9:05 AM, CNA #13 was asked if she placed heel protectors on Resident #4 when he was in bed. CNA #13 stated, "No. I only fresh his heels on that pillow."

During an interview in the second floor hallway on 5/3/11 at 9:15 AM, Nurse #5 was asked about the order for heel protectors for Resident #4. Nurse #5 stated, "If the order says there should be heel protectors there should be heel protectors in his room and they should be used."

F 315 483.25(d) NO CATHETER, PREVENT UTI,
Continued From page 12

F 315

SS0E

RESTORE BLADDER

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review, observation and interview, it was determined the facility failed to provide appropriate treatment and services by allowing urinary drainage bags to touch the floor for 2 of 4 (Residents #6 and 7) sampled residents with urinary catheters.

The findings included:

1. Review of the facility's "INFECTION CONTROL - NURSING" policy documented, "...URINARY TRACT INFECTIONS (UTI)... The bag must never be allowed to touch the floor..."

2. Medical record review for Resident #6 documented an admission date of 9/2/98 with a readmission date of 8/5/08 with diagnoses of Multiple Sclerosis, Paraplegia, Diabetes Mellitus, Neurogenic Bladder, Osteoporosis, Peripheral Vascular Disease and Constipation.

Observations in Resident #6's room on 5/2/11 at
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<th>F 315</th>
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<tr>
<td></td>
<td>10:40 AM, revealed Resident #6's urostomy drainage bag was laying on the floor.</td>
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<td>During an interview on the 3rd floor hallway on 5/4/11 at 1:40 PM, Nurse #7 was asked if Resident #6's drainage bag should ever be on the floor. Nurse #7 stated, &quot;No...it (drainage bag) should be in the privacy bag.&quot;</td>
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<td>3. Medical record review for Resident #7 documented an admission date of 4/21/11 with diagnoses of Urinary Retention, Dysphagia, Depressive Disorder, Hypothyroidism and Chronic Obstructive Pulmonary Disease. Review of the physician's orders dated 4/21/11 documented &quot;...Foley catheter 16 French with 10 cc [cubic centimeters] bulb...&quot;</td>
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<tr>
<th>F 328</th>
<th>SS=5</th>
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<tr>
<td></td>
<td>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</td>
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<td>The facility must ensure that residents receive proper treatment and care for the following special services:</td>
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<td>Injections;</td>
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<td>Parenteral and enteral fluids;</td>
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<td>Colostomy, urostomy, or ileostomy care;</td>
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<td>Tracheostomy care;</td>
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<td>Tracheal suctioning;</td>
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<td></td>
<td>Respiratory care;</td>
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This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review, observations and interview, it was determined the facility failed to ensure oxygen (O2) was administered at the rate prescribed by the physician for 5 of 7 (Residents #7, 10, 12, 13 and 15) sampled residents receiving O2 therapy.

The findings included:

1. Review of the facility's "Oxygen Administration" policy documented, "...Oxygen therapy will be delivered per physicians orders... Verify orders... Turn oxygen to proper flow rate..."

2. Medical record review for Resident #7 documented an admission date of 4/21/11 with diagnoses of Urinary Retention, Dysphagia, Depressive Disorder, Hypothyroidism and Chronic Obstructive Pulmonary Disease. Review of the physician's orders dated 4/21/11 documented, "...O2 @ [at] 3.5LPM [liters per minute] via NG [nasal cannula] continuous..."

Observations in Resident #7's room on 5/2/11 at 10:45 AM and 3:30 PM, revealed Resident #7 was receiving O2 per NC at a rate of 4 LPM.

Observations in Resident #7's room on 5/3/11 at 7:55 AM, 10:55 AM, 2:25 PM and 3:45 PM, revealed Resident #7 was receiving O2 at a rate of 3 LPM.
F 326  
Continued From page 16

During an interview in Resident #7's room on
5/3/11 at 3:45 PM, Nurse #8 confirmed Resident
#7's O2 rate was set at 3 LPM.

3. Medical record review for Resident #10
documented an admission date of 5/4/10 with
diagnoses of Pneumonia, Acute Respiratory
Failure and Encephalopathy. Review of a
physician's order dated 1/13/11 documented,
"...O2@ 2LPM via NC to keep O2 sats
[saturations] > [greater than] 92% [percent]..."

Observations in Resident #10's room on 5/2/11 at
10:25 AM and 3:40 PM and on 5/3/11 at 7:35 AM
and 2:15 PM, revealed Resident #10 lying in bed
receiving O2 at 3L/min.

During an interview in Resident #10's room on
5/3/11 at 2:30 PM, Nurse #6 verified that
Resident #10's O2 rate was set on "...3..."

4. Medical record review for Resident #12
documented an admission date of 10/10/01 and a
readmission date of 11/8/06 with diagnoses of
Congestive Heart Failure, Spinal Stenosis,
Hypertension and Osteoarthritis. Review of the
physician's orders dated 3/29/11 documented,
"...O2 at 2LPM via NC as needed..."

Observations in Resident #12's room on 5/2/11 at
10:25 AM, on 5/3/11 at 2:30 PM and on 5/4/11 at
7:55 AM, revealed Resident #12 was receiving
O2 per NC at a rate of 1.5 LPM.

During an interview in Resident #12's room on
5/4/11 at 8:10 AM, Nurse #6 confirmed Resident
#12's O2 rate was set at 1.5 LPM.
**F 328**

Continued From page 16

5. Medical record review for Resident #13 documented an admission date of 7/24/10 with diagnoses of Osteoporosis, Dementia, Depression and Urinary Retention. Review of a physician's order dated 3/1/11 documented, "...O2 @ 2L/M to maintain sats above 91%..."

Observations in Resident #13's room on 5/2/11 at 10:40 AM and on 5/4/11 at 7:45 AM, 8:35 AM and 9:16 AM, revealed Resident #13 lying in bed receiving O2 per NC at 2.5 L/M.

During an interview in Resident #13's room on 5/4/11 at 9:15 AM, Nurse #5 verified that Resident #13's O2 rate was 2.5 L/M.

6. Medical record review for Resident #15 documented an admission date of 5/24/05 and a readmission date of 1/9/06 with diagnoses of Congestive Heart Failure, Hypertension, Chronic Obstructive Pulmonary Disease and Diabetes Mellitus. Review of the physician's orders dated 2/22/10 documented, "...O2 @ 2LPM via nasal cannula to maintain sats above 90%..."

Observations in Resident #15's room on 5/2/11 at 10:55 AM, revealed Resident #15 receiving O2 per binastral cannula at a rate of 3.5 LPM.

Observations in Resident #15's room on 5/4/11 at 8:20 AM and 1:24 PM, revealed Resident #15 receiving O2 per binastral cannula at a rate of 3 LPM.

During an interview in the 3rd floor nurses' station on 5/4/11 at 1:32 PM, Nurse #6 confirmed Resident #15's O2 was being administered at 3 LPM.
F 333 F 333
SS=1D

483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS

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

This REQUIREMENT is not met as evidenced by:
Based on review of "MED-PASS COMMON INSULINS" provided by the American Society of Consultant Pharmacists, medical record review, observation and interview, it was determined 1 of 6 (Nurse #6) nurses administering medications failed to ensure that residents were free of significant medication errors.

The findings included:
Review of the "MED-PAS COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties" provided by the American Society of Consultant Pharmacists for typical dosing administration of insulin related to meals documented, "...NovoLog...ONSET...15 min (minutes)...TYPICAL ADMINISTRATION/COMMENTS...15 minutes before or within 20 minutes after eating..."

Medical record review for Random Resident (RR) #1 documented an admission date of 4/7/11 with diagnoses of Knee Joint Replacement, Diabetes and Chronic Kidney Disease. Review of the physician's orders dated 4/7/11 documented, "...NovoLog...per sliding scale...Four Times A Day..."

Observations in RR #1's room on 5/2/11 at 11:42 AM, Nurse #6 administered 2 units of NovoLog insulin to RR #1. RR #1 did not receive her meal
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CILA IDENTIFICATION NUMBER: 445203</th>
<th>(X2) MULTIPLE CONSTRUCTION A: BUILDING ____________ B: WING ____________</th>
<th>(X3) DATE SURVEY COMPLETED 05/04/2011</th>
</tr>
</thead>
</table>

**NAME OF PROVIDER OR SUPPLIER**

**WEST MEADE PLACE**

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

1000 ST LUKE DRIVE

NASHVILLE, TN 37205

<table>
<thead>
<tr>
<th>(X4) ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 333</td>
<td></td>
<td>Continued From page 18 tray until 12:30 PM with her first bite taken at 12:35 PM. The administration of the Novolog insulin 53 minutes before RR #1 received her meal tray resulted in a significant medication error. During an interview in the second floor Unit Manager's office on 5/3/11 at 2:50 PM, Nurse #11 was asked what is the expectation of insulin administration and the time of meal service. Nurse #11 stated the meal tray should have been there when the Novolog insulin was given. During an interview in the Director of Nursing's (DON) office on 5/4/11 at 10:40 AM, the DON was asked what is the expectation of insulin administration and the time of meal service. The DON stated the nurses &quot;...need to have the tray in eye sight...&quot; before giving Novolog insulin.</td>
<td>F 333</td>
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<tr>
<td>F 431 SS=0</td>
<td>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</td>
<td>F 431</td>
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<td>F 431</td>
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<td>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.</td>
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<td>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.</td>
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<tr>
<td>F 431</td>
<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on observation and interview, it was determined the facility failed to ensure 1 of 6 (Nurse #10) nurses observed administering medications did not leave medications unattended and out of view.</td>
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<td>The findings included:</td>
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<td>Observation in Random Resident (RR) #2's room on 5/2/11 at 5:05 PM, Nurse #10 left a cup of pills unattended on the overbed table in RR #2's room, when she left the room to return RR #2 to her room from the dining room. The cup of pills was left unattended and out of nurses view.</td>
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<td>During an interview on the 2nd floor Unit Manager's office on 5/3/11 at 2:55 PM, Nurse #11 stated, &quot;...they [nurses] know they should not...&quot;</td>
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<td>The facility does and will continue to ensure that medications are stored in a locked compartment on the med cart when unattended.</td>
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<td>1. Immediate and corrective action took place on 5/5/11. It was verified through observation on 5/5/11, per nurse monitor that Nurse #10 administered medications to random Resident #2 correctly and maintained medications in a locked compartment when needed to leave them unattended. Nurse #10 was in-service on 5/5/11, per the DON/NEC on proper procedure for safe storage of medications under lock and key when left unattended.</td>
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<td>2. By in-serviceing all facility nurses regarding proper procedures for safe storage of medications will insure all resident meds are maintained in a safe lock compartment. An in-service was conducted on 5/10/11, per the DON/NEC with all nursing staff.</td>
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<td>3. DON or designee will conduct random audits of safe storage of medications weekly X1, monthly X2, then PRN until 100% compliance is achieved, then annually.</td>
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<td>4. Findings will be reported to the QA committee consisting of the Admin., Asst Admin., BSN, ADCN, Nurse Managers, QA Nurse, Nurse Educator and Department Heads monthly for follow up and review and for recommendations for improvement with deficiencies.</td>
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</table>
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLA**

**IDENTIFICATION NUMBER:**

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<th>DSS COMPLETION DATE</th>
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<tbody>
<tr>
<td>F431</td>
<td></td>
<td>Continued From page 20 leave medications in the room or on the med [medication] carts unattended...”</td>
<td>F431</td>
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<tr>
<td>F441</td>
<td>SS=E</td>
<td>483.66 INFECTION CONTROL, PREVENT SPREAD, LINENS</td>
<td>F441</td>
<td></td>
<td>The facility does and will continue to maintain practices to prevent the potential spread of infection.</td>
<td></td>
</tr>
</tbody>
</table>

(a) Infection Control Program
The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of
Continued From page 21
infection.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review, observation and interview, it was determined 5 of 11 (Nurses #1, 2, 3, 7 and 10) nurses failed to follow infection control practices to prevent the potential spread of infection by not wearing gloves during an accuchek and administration of insulin, not washing hands, handling food bare handed and not cleaning a contaminated bottle of wound cleanser prior to returning the cleanser to the cart.

The findings included:

1. Review of the facility's "Hand washing/Hand Hygiene" policy documented, "...This facility considers hand washing/hand hygiene as the primary means to prevent the spread of infections.... 1. All personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors... When to Wash Hands... b. After handling items potentially contaminated with blood, body fluids, or secretions... Using Gloves. 4. The use of gloves does not replace hand washing/hand hygiene... Washing Hands Using Soap... Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel..."

2. Observations in the 3rd floor dining room on 5/1/11 at 5:00 PM revealed the following:
b. Nurse #7 patted a resident on the cap,
Continued From page 22
readjusted the bbl on the resident, opened the milk carton, opened the ice cream cup, and handled the silverware without washing her hands or cleaning her hands with hand sanitizer.

a. Nurse #1 removed the lettuce from a resident's sandwich, put the sandwich back together with her bare hands and held the half sandwich with her bare hands for the resident to take a bite.

Observations in the 3rd floor dining room on 5/3/11 at 7:28 AM revealed the following:

b. Nurse #1 used her bare hands to break a biscuit into 3 pieces for a resident, poured the gravy over the biscuit pieces, opened the orange juice and milk and then handed the fork to the resident to begin eating.

c. Nurse #1 moved a stool over to a table, touched the resident's arm to awaken him and began feeding him eggs and coffee. While Nurse #1 continued to feed the resident she put a napkin on the resident's chest, moved a chair to the table, and adjusted the resident's cap without washing her hands or cleaning her hands with hand sanitizer.

During an interview in the Director of Nursing's (DON) office on 5/4/11 at 10:45 AM, the DON was asked if touching the resident's food barehanded is acceptable. The DON stated, "...No, should never [handle the food barehanded]..."

3. Observations in Random Resident (RR) #2's room on 5/2/11 at 5:05 PM, Nurse #10 did not wear gloves while performing an accuchek or when administering an insulin injection.

During an interview in the 2nd floor Unit
Continued From page 23

Manager's office on 5/3/11 at 2:55 PM, Nurse #11 was asked what is the expectation of wearing gloves during accuchek performance and insulin administration. Nurse #11 stated the nurses should wear gloves when performing accucheks.

During an interview in the Director of Nursing's (DON) office on 5/4/11 at 10:40 AM, the DON was asked what is the expectation of wearing gloves during accuchek performance and insulin administration. The DON confirmed the nurses should wear gloves when performing accucheks and giving injections.

4. Review of the facility's "Dressing-Non-Sterile" policy documented. 

"...PURPOSE: Designated partner will use no-sterile dressings when indicated on Care Plans and/or per physician's orders...
10. Open dressing materials.
11. Put on gloves and remove soiled dressing and discard in appropriate container.
12. Remove and discard gloves.
13. Wash your hands.
14. Clean wound with prescribed solution with 4 x [by] 4 gauze pads..."

- Observation in Resident #2 room on 5/3/11 at 2:45 PM, Nurse #3 (wound care specialist) performed a dressing change on Resident #2's bilateral heels, left lower leg and sacrum area. Nurse #3 did not remove her gloves or wash her hands between wounds. Nurse #3 removed her gloves to do wound care on the sacrum area and applied clean gloves without washing her hands.

During an interview outside the conference room on 5/4/11 at 10:15 AM, the Director of Nursing (DON) confirmed that Nurse #3 failed to follow
Continued from page 24
the facility's policy and procedures.

b. Observation in Resident #2's room on 5/3/11 at 10:25 AM, Nurse #2 (treatment nurse) put supplies on Resident #2's overbed table, washed her hands and turned the faucet off with her bare hands. After Nurse #2 assisted Nurse #3 with removal of the dressing on the resident's right foot, Nurse #2 removed her gloves, washed her hands and turned the faucet off with her bare hands.

5. Observation in Resident #14's room on 5/3/11 at 2:45 PM, Nurse #2 applied Santyl to Resident #14's bilateral heels with gloved hands, applied dressings, removed her gloves and washed her hands. Nurse #2 picked up the bottle of wound cleaner and picked the red bag up from the floor along with a clear bag. The bottle of wound cleaner touched both bags contaminating the bottle of wound cleaner and placed the bottle of wound cleaner back in the cart with the other supplies without cleaning the bottle.

F 497
483.76(e)(6) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE

The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff, and for nurse aides providing services to individuals with
F 497 Continued From page 25 cognitive impairments, also address the care of the cognitively impaired.

This REQUIREMENT is not met as evidenced by:

Based on review of the Certified Nursing Assistants (CNA) 2010 in-service training records and interview, it was determined the facility failed to ensure 12 of 26 (CNAs #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12) received no less than 12 hours of in-service training for the year 2010.

The findings included:

Review of the training program attendance records for 1/1/10 through 12/31/10 revealed 12 of 26 CNAs failed to receive 12 hours of in-service training for the 2010 year. The in-service hours attended were documented as follows:

- CNA #1 with a hire date of 8/7/09 had 11.25 hours (hrs).
- CNA #2 with a hire date of 8/10/00 had 11.25 hrs.
- CNA #3 with a hire date of 11/27/00 had 10.25 hrs.
- CNA #4 with a hire date of 6/18/01 had 8.25 hrs.
- CNA #5 with a hire date of 7/14/05 had 6.50 hrs.
- CNA #6 with a hire date of 1/25/09 had 9.25 hrs.
- CNA #7 with a hire date of 12/29/05 had 9.25 hrs.
- CNA #8 with a hire date of 5/20/06 had 1.50 hrs.
- CNA #9 with a hire date of 12/16/08 had 1.50 hrs.

F 497

The facility does and will continue to ensure that certified nursing assistants receive no less than 12 hours of in-service education per year.

1. Immediate and corrective action took place on 5/10/11. All facility nursing staff in-serviced per the DON/NEC on the requirement for all certified nursing assistants to have 12 hours of in-service training education per year. C.N.A. #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 and 12 given “in the know” training brochures/in-services (1 hour CEU per brochure/training session) on 5/8/11, 5/8/11, 5/8/11, 5/8/11, and 5/9/11 per the Nurse Educator Coordinator to ensure the total in-service hours will be up to 12 for each C.N.A. for 2011.

2. By in-servicing all facility nurses regarding the requirements for all certified nursing assistant to have 12 hours of in-service education per year and by providing the “in the know” training brochures/in-services to the certified nursing assistants this will ensure the residents receive care form competent certified nursing assistants. All facility nursing staff in-serviced per the DON/NEC on requirement for all certified nursing assistants to have no less than 12 hours of in-service education per year on 5/10/11.

3. DON or designee will conduct random audits of C.N.A. training hours monthly X 3 then PRN until 100% compliance is obtained then annually.

4. Findings will be reported to the QA committee consisting of the Admin., Asst Admin., DON, ADON, Nurse Managers, QA Nurse, Nurse Educator, and Department Heads monthly for follow up and review and for recommendations for improvement with deficiencies.

Completion Date: 5/10/11
<table>
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</table>
| F 497         | Continued From page 26 hours.  
  j. CNA #10 with a hire date of 4/22/09 had 6.00 hours.  
  k. CNA #11 with a hire date of 8/22/07 had 2.25 hours.  
  l. CNA #12 with a hire date of 7/5/00 had 11.25 hours.  
  During an interview in the Director of Nursing (DON) office on 5/4/11 at 2:05 PM, the receptionist stated, "I have already added all of them [referring to in-service hrs]. I went back to last year book and most of them were all doubles."  
  During an interview in the DON office on 5/4/11 at 2:07 PM, the Assistant Director of Nursing stated, "These are all the in-services we have. If we don't have it, we don't have it." | F 497         |                                                                                                                  |                |