### Statement of Deficiencies and Plan of Correction

#### Name of Provider or Supplier
**NHC HEALTHCARE, DICKSON**

#### Address
**812 CHARLOTTE ST, DICKSON, TN 37055**

#### Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix Tag</th>
<th>Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
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</thead>
<tbody>
<tr>
<td>F 280</td>
<td>SS=d</td>
<td>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</td>
<td>The patient will continue to have a comprehensive care plan developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</td>
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This REQUIREMENT is not met as evidenced by:

Based on medical record reviews, observations and interviews, it was determined the facility failed to revise the comprehensive care plan to address range of motion (ROM) and/or oxygen (O2) for 4 of 27 (Residents #4, 6, 19 and 22) sampled residents.

The findings included:

1. Medical record review for Resident #4 documented an admission date of 11/14/18 with diagnoses of Aphasia, Dysarthria, Multiple Sclerosis, Chronic Obstructive Pulmonary

   **Signature**: [Signature]

#### Laboratory Director's or Provider/Supplier Representative's Signature

**Admirable**

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
Disease, Hypertension, Diabetes, Anxiety and Right Hemiparesis. Review of the Minimum Data Set (MDS) with an assessment reference date of 10/16/10 documented Resident #4 had impairment on both sides of the upper and lower extremities for ROM. Review of the care plan dated 11/6/10 revealed no documentation to address ROM limitations.

During an interview in the care plan office on 11/16/10 at 3:50 PM, MDS Coordinator #1 confirmed there was no care plan to address ROM and stated, "I am going to add it right now."

2. Medical record review for Resident #5 documented an admission date of 1/30/09 and a re-admission date of 7/3/10 with diagnoses of Dysphagia, Dementia, Alzheimer's, Chronic Anemia, Hypertension, Chronic Obstructive Pulmonary Disease, Ischemic Colitis and Protein-Calorie Malnutrition. Review of the MDS with an assessment reference date of 10/4/10 documented Resident #5 had impairment on both sides of the upper and lower extremities for ROM. Review of the care plan dated 10/5/10 revealed no documentation to address ROM limitations.

During an interview at the unit 2 nurses' station on 11/17/10 at 8:30 AM, MDS Coordinator #1 stated, "No, it's [ROM] not in the ADLs [activities of daily living] where it [ROM] should be..."

3. Medical record review for Resident #19 documented an admission date of 6/18/07 with diagnoses of Emphysema, Chronic Obstructive Pulmonary Disease, Depression, Anorexia, Peripheral Neuropathy, Orthostatic Hypotension and Dementia with Delusions. Review of Resident #19's physician's orders dated 10/20/10

The D.O.N. will be responsible for compliance and will report to the QA committee monthly beginning 12/23/10 until substantial compliance is met.
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<tr>
<td>F 280</td>
<td>Continued From page 2</td>
<td>F 280</td>
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<td>11/17/2010</td>
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**Continued From page 2**

"...O2 @ [at] 3L [liters] PER NC [nasal cannula] CONTINUOUS..." Review of the nurse's notes dated 11/15/10 documented Resident #19 was receiving O2 continuous at 2 liters per minute (LPM). Review of the care plan dated 9/22/10 revealed no care plan for O2 therapy.

Observations in room 400 on 11/15/10 at 10:15 AM, on 11/16/10 at 4:00 PM and on 11/17/10 at 9:25 AM, revealed Resident #19 lying in bed with O2 in use.

During an interview at the unit 4 nurses' station on 11/17/10 at 9:35 AM, Nurse #3 stated, "I don't see oxygen on here [care plan]. It should be. Looks like there's a problem with the care plan."

4. Medical record review for Resident #22 documented an admission date of 7/12/08 with diagnoses of Alzheimer's, Parkinson's, Late Effects Carebровascular Disease, Congestive Heart Failure, Aneurism, Contractures, Hypertension, Dysphagia, Supraventricular Tachycardia, Osteoarthritis, Anorexia and Diabetes. Review of the physician's orders dated 9/19/10 documented, "...O2 @ 2L PER NC..." Review of the care plan dated 9/16/10 revealed no care plan for O2 therapy.

Observations in room 403 on 11/16/10 at 4:10 PM and on 11/17/10 at 8:30 AM, revealed Resident #22 lying in bed receiving O2 at 2 LPM per NC.

During an interview in the care plan office on 11/17/10 at 10:20 AM, MDS Coordinator #1 confirmed there was no care plan for O2 therapy and stated, "It looks like I need to make some updates, I will add [O2 to care plan] now."
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<th>COMPLETION DATE</th>
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<tr>
<td>F 282 SS-D</td>
<td><strong>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</strong></td>
<td>F 282</td>
<td><strong>The Center will continue to provide services by qualified people in accordance with each patients written plan of care.</strong></td>
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<td><strong>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</strong></td>
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<td><strong>Patient #3 is receiving Reddy shakes on tray as written in care plan.</strong></td>
<td>11/17/2010</td>
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<tr>
<td></td>
<td><strong>This REQUIREMENT is not met as evidenced by:</strong></td>
<td></td>
<td><strong>All patients with Reddy shakes on care plan checked for accuracy of receiving Reddy shakes.</strong></td>
<td>11/17/2010</td>
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<td>Based on medical record reviews, observations and interviews, it was determined the facility failed to follow interventions on the care plan for Reddy shakes or hand splints for 2 of 24 (Residents #3 and #9) sampled residents.</td>
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<td><strong>Patient #9 is receiving her hand splints placed on her as written in the care plan.</strong></td>
<td>11/18/2010</td>
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<tr>
<td></td>
<td>The findings included:</td>
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<td><strong>All patients with splint orders checked for accuracy of placement/schedule.</strong></td>
<td>11/17/2010</td>
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<tr>
<td></td>
<td><strong>1. Medical record review for Resident #3 documented an admission date of 2/26/10 with diagnoses of Decubitus Ulcer Cocyx, Chronic Diarrhea, Malnutrition, End Stage Renal Disease (ESRD), Hypertension, Spinal Stenosis, History of Bladder Cancer, Gastroesophageal Reflux Disease and Depression.</strong></td>
<td></td>
<td><strong>Dietary partners serving meals were inserviced on checking trays for accuracy before it is taken to the patient by the Dietary Manager.</strong></td>
<td>11/18/2010</td>
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<td>Review of the comprehensive care plan dated 10/29/10 documented, &quot;Significant nutritional risk... Malnutrition... Supplement Use between meals... 1 [one] 4 oz [ounce] Reddy Shake c [with] each meal for add [additional] /Calories/Prot. [protein].&quot;</td>
<td></td>
<td><strong>CNA's were inserviced by Registered Dietician on how to accurately read tray cards and place items on tray.</strong></td>
<td>11/18/2010</td>
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<td></td>
<td>Observations in Resident #3's room on 11/16/10 at 8:00 AM and on 11/17/10 at 7:40 AM, revealed no Reddy Shake on Resident #3's meal tray as care planned.</td>
<td></td>
<td><strong>Registered Dietician will QA weekly x 4 or until substantial compliance is met.</strong></td>
<td>11/18/2010</td>
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<td>During an interview in the Director of Nursing's (DON) office on 11/17/10 at 8:00 AM, the DON was asked about the Reddy Shakes. The DON</td>
<td></td>
<td><strong>Licensed Nurses and CNA's inserviced on splint placement and splint schedule according to Care Plan by the Team Coordinators.</strong></td>
<td>11/17/2010</td>
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<td></td>
<td><strong>Team Coordinators will QA weekly x 4 or until substantial compliance is met.</strong></td>
<td></td>
<td><strong>The D.O.N. will be responsible for compliance and will report to the QA Committee monthly</strong></td>
<td>11/17/2010</td>
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Continued From page 4

stated, "It would be between dietary and nursing to make sure the supplement is on the tray."

During an interview in the education room on 11/17/10 at 10:00 AM, Dietician #1 was asked about the Reddy Shakes. Dietician #1 stated, "...The CNA [Certified Nursing Assistant] just didn't put it [Reddy shake] on her tray, it wasn't that she [Resident #3] refused it."

2. Medical record review for Resident #9 documented an admission date of 5/14/10 and a readmission date of 9/9/10 with diagnoses of Late Effects Traumatic Brain Injury, Gastrostomy, Tracheostomy, Pressure Ulcer Occipital, Deep Vein Thrombosis Upper Extremity, Hydrocephalus and Pneumonia. Review of the comprehensive care plan dated 8/23/10 and updated 8/25/10 documented, "...ADL's [Activities of Daily Living]. Dependent on staff for ADLS... Bilateral hand splints to both hands: On while facing the door and off while facing the window..."

Observations in Resident #9's room on 11/15/10 at 5:10 PM, on 11/16/10 at 10:15 AM and 12:00 PM and on 11/17/10 at 7:35 AM, revealed Resident #9 lying in bed facing the door, with no bilateral hand splints on as care planned.

During an interview in the 100 hall on 11/17/10 at 8:15 AM, Nurse #2 was asked about Resident #9 not having the hand splints on. Nurse #2 stated she was not aware Resident #9 should have hand splints on.

The facility must ensure that residents receive proper treatment and care for the following needs:

- Parenteral & Enteral fluids, colostomy, urostomy, or ileostomy care; tracheostomy, tracheal suctioning.

The center will continue to ensure that patients receive proper treatment and care for the following special services: Injections, Parenteral & Enteral fluids, colostomy, urostomy, or ileostomy care; tracheostomy, tracheal suctioning.
**F 328** Continued From page 5

**F 328**

<table>
<thead>
<tr>
<th>ID</th>
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<tbody>
<tr>
<td>F 328</td>
<td>Respiratory care, foot care, and prostheses.</td>
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<tr>
<td></td>
<td>Patient #2 02 rate was adjusted to follow correct rate as prescribed by physician.</td>
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<td></td>
<td>Respiratory Therapist checked current patients with 02 orders to ensure they were accurate as prescribed by the physician.</td>
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<td></td>
<td>Licensed Nurse staff and Respiratory Therapist inserviced on checking 02 rate daily every shift and when in patient room.</td>
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<td></td>
<td>The Respiratory Therapist and/or D.O.N. will be responsible for compliance and will report to the QA Committee monthly beginning 12/23/10 until substantial compliance is met.</td>
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</table>

Special services:
- Injections;
- Parenteral and enteral fluids;
- Colostomy, ureterostomy, or ileostomy care;
- Tracheostomy care;
- Tracheal suctioning;
- Respiratory care;
- Foot care; and
- Prostheses.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observations and interviews, it was determined the facility failed to ensure oxygen (O2) was administered at the physician's prescribed rate for 1 of 12 (Resident #2) sampled residents receiving oxygen.

The findings included:

Medical record review for Resident #2, documented an admission date of 4/28/10 with diagnoses of Congestive Heart Failure, Chronic Renal Insufficiency, Hypertension, Atherosclerotic Heart Disease, Depression and Dysarthria.

Review of the physician's telephone orders dated 10/26/10 documented, "...change O2 to 2 [liters] PRN [as needed] for SCB [shortness of breath]...."  

Observations in Resident #2's room on 11/15/10 at 10:30 AM and 2:10 PM, revealed Resident #2 was receiving O2 at 3 liters per minute (LPM) per binaleral cannula (BNC). Resident #2 was not receiving oxygen at the physician's prescribed rate of 2 LPM.

Observations in Resident #2's room on 11/16/10 at 7:45 AM, revealed Resident #2 was receiving...
**F 328** Continued From page 6

C2 at 3 1/2 LPM per BNC. Resident #2 was not receiving oxygen at the physician's prescribed rate of 2 LPM.

During an interview in Resident #2's room on 11/16/10 at 7:45 AM, Nurse #7 was asked what rate was Resident #2's oxygen set on. Nurse #7 bent down and looked at the oxygen concentrator and stated, "It is on 3 and 1/2 liters."

During an interview at the nurse's station on 11/16/10 at 9:55 AM, Nurse #8 was asked what rate was Resident #2's C2 ordered for. Nurse #8 stated, "2 Liters."

**F 371**

483.35(i) FOOD PROCURE.

SS=E
STORE/PREPARE SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on policy reviews, observations and interviews, it was determined 4 of 8 (dietary staff members #1, 2, 3 and 4) dietary staff members failed to ensure food was prepared or stored under sanitary conditions as evidenced by rice stored in an open bag; a Teflon skillet had scratches and a carbon build up; dirty towels and cloths on counters and carts; improper storage of a broom; cover their hair and beards or follow the Dietary Manager placed the rice in an appropriate container, the teflon skillet was discarded and replaced with a new teflon skillet. Dirty towels and cloths were placed in appropriate containers. The broom was placed in it's proper storage area. The partners were instructed to cover their hair and beards and then instructed on proper handwashing techniques.

Dietary Manager checked each of the following: food stored in appropriate containers, each teflon skillet for carbon build up, dry towels and cloths, storage of brooms, each dietary partner for proper restraints, proper handwashing of each dietary partner.

3. Dietary Manager inserviced dietary
### F 371
Continued From page 7

Handwashing policy.

The findings included:

1. Review of the facility's "DRY STORAGE" policy documented, "...GUIDELINES... 6. Foods will be stored in their original packages, if possible. If opened, packages should be closed securely to protect product.""

Observations in the kitchen on 11/15/10 at 10:00 AM and 4:18 PM and on 11/16/10 at 3:35 PM, revealed a large open bag of rice stored on a shelf in the food preparation area.

During an interview in the kitchen on 11/16/10 at 3:35 PM, the Dietary Manager stated, "It [rice] should be in a closed container to keep something from getting in it."

2. Observations in the kitchen on 11/15/10 at 4:18 PM, revealed the cook preparing a grilled cheese sandwich in a skillet that had missing Teflon, multiple scratches on the inside and large amounts of carbon buildup along the top edge and bottom.

During an interview in the Dietary Manager's (DM) office on 11/16/10 at 8:15 AM, the DM held the Teflon skillet and stated, "It has too much carbon. This one should have been taken out. It shouldn't be used."

3. Observations in the kitchen on 11/15/10 at 10:00 AM, revealed a dirty dry towel on the food preparation counter and on 11/15/10 at 4:38 PM revealed a dirty wet towel on the floor next to the racks of clean cups and bowls.

Dietary Manager will QA weekly x 4 for accuracy and will continue until substantial compliance is met.

Dietary Manager will QA monthly beginning 12/23/10 until substantial compliance is met.
F 371 Continued From page 8

Observations in the kitchen on 11/16/10 at 8:20 AM, revealed a dirty wet cloth hanging on top of the clean dish rack.

Observations in the kitchen on 11/16/10 at 3:15 PM, revealed 2 dirty towels hanging on the end of a utility cart.

During an interview in the kitchen on 11/16/10 at 3:15 PM, the DM was asked what he would expect staff to do with towels and cloths that have been used. The DM stated, "They should put the towels in the bin for dirty and the wet cloths in the sanitizing solution in a bucket." After looking at the dirty towels on the utility cart the DM confirmed the towels should not be left in the kitchen.

4. Observations in the kitchen on 11/16/10 at 8:15 AM, revealed a broom with the bristles up resting on the end of the clean dish counter.

5. Review of the facility's "PERSONAL HYGIENE" policy documented, "...3. Hair restraints. Dietary partners shall wear hair restraints such as hats, hair coverings, or nets, beard restraints, and worn to effectively keep hair from contacting exposed food; clean equipment, utensils, and linens."

Observations in the kitchen on 11/15/10 at 10:05 AM, revealed dietary staff member #2 placed eating utensils in napkins and moved a cart of prepared desserts with his beard uncovered.

Observations in the kitchen on 11/15/10 at 10:16 AM, revealed dietary staff member #1 went throughout the kitchen wearing a cap. Her hair was not covered.
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<td>Continued From page 9</td>
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<td>11/17/2010</td>
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<tr>
<td></td>
<td>Observations in the kitchen on 11/16/10 at 8:15 AM and 8:40 AM, revealed dietary staff member #3 was cooking at the stove and was working at the prep table wearing a cap. His hair and beard was not covered.</td>
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<td>Observations on the 400 unit on 11/16/10 at 11:35 AM, revealed dietary staff member #1 served food from the steam table wearing a cap. Her hair was not covered.</td>
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<td>Observations in the kitchen on 11/16/10 at 3:15 PM, revealed dietary staff member #4 was working in the food prep area. His beard was not covered.</td>
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<td>Observations in the kitchen on 11/17/10 at 9:30 AM, revealed dietary staff member #3 was cooking at the stove and was working at the prep table wearing a cap. His hair was not covered.</td>
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<td>During an interview in the DM's office on 11/17/10 at 9:30 AM, the DM was asked if the dietary staff was expected to have their hair and beards covered. The DM stated, &quot;They wear nets or caps and a beard cover.&quot; The Regional-Registered Dietician stated, &quot;They wear the caps, but their hair in the back is short and not covered.&quot;</td>
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<td>6. Review of the facility's &quot;HAND WASHING&quot; policy documented, &quot;...All partners handling food products or contacting equipment used in food preparation should wash their hands... 1. Hands should be washed... after leaving and returning to a food preparation area...&quot;</td>
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<td>Observations in the kitchen on 11/15/10 at 4:20 PM, revealed dietary staff member #2 left the</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

NHC HEALTHCARE, DICKSON

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

812 CHARLOTTE ST

DICKSON, TN 37055

**DATE SURVEY COMPLETED**

11/17/2010

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<td>F 371</td>
<td>3</td>
<td>Continued From page 10 department to take a cart out and returned to the department. Dietary staff member #2 did not wash his hands after returning to the department or before beginning to roll silverware. During an interview in the kitchen on 11/15/10 at 4:25 PM, dietary staff member #2 was asked if he had washed his hands. Dietary staff member #2 stated, &quot;No, I did not wash my hands.&quot;</td>
<td>F 441</td>
<td>3</td>
<td>The Center will continue to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it: (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which</td>
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<tr>
<td>F 441</td>
<td>S</td>
<td>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</td>
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<td>The Center will continue to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it: (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which</td>
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**F O R M 2907 (12-09) Previous Versions Obsolete**

**Event ID:** 9SDY11

**Facility ID:** TN2203

**If continuation sheet Page 11 of 19**
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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 infection.

This REQUIREMENT is not met as evidenced by:
Based on policy reviews, observations and interviews, it was determined the facility failed to ensure practices to prevent the potential spread of infection were maintained by 2 of 2 (Nurses #9 and 10) nurses observed during wound care; 4 of 7 (Nurses #1, 2, 3 and 4) nurses observed during medication administration; and 6 of 14 Certified Nursing Assistants (CNAs #1, 2, 3, 4, 5 and 6) and Occupational Therapist (OT #1) observed during dining observations.

The findings included:

1. Review of the facility's "HANDWASHING" policy documented, "PURPOSE: To decrease the number of microorganisms, preventing cross contamination, ...Procedure wash hands after contact with each patient, after toileting, smoking or eating, and after removal of gloves...".

2. Observations during wound care in Resident #3's room on 11/16/10 at 9:00 AM, Nurse #9 pushed the paper towel dispenser handle for a paper towel, washed her hands, dried her hands with the paper towel, took the same paper towel and dispensed more paper towel, then dried her hands with the fresh paper towel and the towel...
Continued From page 12
she had used on the dispenser. Nurse #9 dried her hands in this same way three times during observation of the wound care. Nurse #9 cross contaminated her hands when she use the dirty paper towel to dry her hands.

During an interview in the biohazard room on 11/16/10 at 9:15 AM, Nurse #9 stated, "...I should not have dried with the dirty paper towel..."

Observations during wound care in Resident #11’s room on 11/28/10 at 11:08 AM, revealed Nurse #10 dispensed some paper towel, washed her hands, dried her hands with that towel, used her bare index finger on her clean right hand to dispense more paper towel to turn the water off. Nurse #10 used this same technique contaminating her right hand 4 times during observation of her wound care.

During an interview in the Director of Nursing’s (DON) office on 11/16/10 at 11:35 AM, the DON stated, "...She [Nurse #9] should not have dried her hands with dirty towel... She [Nurse #10] should have used the paper towel to get the other papers down..."

3. Observations in room 210 on 11/15/10 at 4:45 PM, Nurse #1 removed her gloves after checking the resident’s blood sugar. Nurse #1 did not wash her hands immediately after removing gloves and prior to cleaning the glucometer.

4. Observations in room 104 on 11/15/10 at 5:20 PM, Nurse #2 pulled the resident’s gown up with gloved hands and repositioned the resident on her back. Nurse #2 continued to check placement of a Percutaneous Endoscopy Gastrostomy (PEG) tube and administer medications through
Continued From page 13

the PEG tube. Nurse #2 did not remove her gloves or wash her hands after resident contact or prior administering medications per the PEG tube.

5. Observations in room 300 on 11/16/10 at 6:20 AM, Nurse #3 removed gloves after checking the resident's blood sugar. Nurse #3 donned gloves and applied a medication patch to the resident's chest wall. Nurse #3 removed gloves, donned clean gloves, cleaned the glucometer and removed her gloves. Nurse #3 did not wash her hands after removing gloves.

6. Observations at the medication cart in front of room 223 on 11/16/10 at 9:30 AM, Nurse #4 applied gloves, opened a medication capsule, emptied the contents of the capsule into the medication cup, mixed the medication with pudding and then removed her the gloves. Nurse #4 entered room 223, applied gloves, repositioned the resident in bed, then administered the medications to the resident. Nurse #4 did not wash her hands after removing gloves, after resident contact or prior to administering the medications.

7. Observations in room 404 on 11/16/10 at 7:40 AM, CNA #1 opened the straw and touched the straw with her bare hand.

8. Observations in room 213 on 11/16/10 at 7:23 AM, CNA #2 placed the breakfast tray on the overbed table, assisted the resident to a sitting position, covered the resident's legs with a blanket, pulled the overbed table by the resident and proceeded to set up the tray removing tops from liquids and foods and opened the silverware without washing her hands.
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NHC HEALTHCARE, DICKSON

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Observations in the Independent dining room on 11/16/10 at 7:30 AM, CNA #2 dropped a piece of paper on the floor, picked up the paper, placed the paper in the trash and pulled a tray from the clean cart for another resident without washing her hands.

9. Observations in room 206 on 11/26/10 at 7:35 AM, CNA #3 placed the tray on the overbed table, turned the light switch on, then proceeded to open and set up the residents food tray without washing her hands.

10. Observations in the Independent dining room on 11/16/10 at 7:18 AM, CNA #4 touched a resident’s straw with her bare hands.

Observations in room 313 on 11/16/10 at 7:38 AM, CNA #4 touched the biscuit and sausage with her bare hands while serving the breakfast tray.

Observations in the Independent dining room on 11/16/10 at 11:00 AM, CNA #4 touched a resident’s straw with her bare hands, pushed a resident’s wheelchair and pulled a tray from the clean cart for another resident without washing her hands.

Observations in the Independent dining room on 11/16/10 at 11:35 AM, CNA #4 touched the resident’s bread with her bare hands.

11. Observations in room 127 on 11/16/10 at 7:30 AM, CNA #5 washed her hands and turned the water off with her bare hands. CNA #5, then delivered a breakfast tray to room 124B, set the tray on the overbed table, applied gloves, emptied...
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the bedpan and removed her gloves. CNA #5 did not wash her hands. CNA #5 went back into the resident's room, positioned the resident in the bed and proceeded to set up the residents meal tray. CNA #5 then washed her hands and turned off the water with her bare hands instead of using a paper towel.

Observations in room 409 on 11/16/10 at 7:50 AM, CNA #5 touched the resident, manually raised the head of bed, opened and touched the straw with her bare hand and began to feed the resident without washing her hands.

Observations in the dining room on 11/16/10 at 11:20 AM, CNA #5 washed her hands and turned off the water with her bare hands, then touched a resident on the back, touched a staff member and proceeded to obtain a cup of coffee for a resident without washing her hands.

Observations in the dining room on 11/16/10 at 11:50 AM, CNA #5 served 2 meal trays, touched a resident then continued to serve the trays. CNA #5 removed an ink pen from her pocket then washed her hands and turned the water off with her bare hands.

Observations in the dining room on 11/16/10 at 12:05 PM, CNA #5 assisted a resident to sit down in the wheelchair, took a plate from the table and scraped it off, cleaned up a spill from the floor, took the towels to the soiled utility room, then washed her hands and turned off the water with her bare hands.

12. Observations in room 421 on 11/16/10 at 8:05 AM, CNA #5 opened the straw and touched the straw with her bare hand.
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Observations in room 421 on 11/16/10 at 8:10 AM, CNA #6 washed her hands and turned the faucet off with her bare hand.

13. Observations in room 309 on 11/16/10 at 7:30 AM, OT #1 entered room 309 and placed the breakfast tray on the overbed table. OT #1 repositioned the resident in the bed, raised the head of the bed and washed the resident's hands with a Sani-Hands cloth. OT #1 continued to serve the tray and feed the resident. OT #1 did not wash her hands after direct resident contact.

14. During an interview in the Director of Nursing office on 11/17/10 at 10:45 AM, The Director of Nursing stated, "Would expect them [staff] to wash hands after removing gloves as well as after emptying bedpan."

During an interview at the unit 4 nurses' station on 11/17/10 at 1:45 PM, Nurse #8 stated, "I expect the bare hand not to touch the straw once the wrapper is removed."

The center will continue to maintain clinical records on each patient in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;
This REQUIREMENT is not met as evidenced by:

Based on medical record reviews and interviews, it was determined the facility failed to ensure physician's orders were accurate for 2 of 27 (Residents #11 and 16) sampled residents.

The findings included:

1. Medical record review for Resident #11 documented an admission date of 6/20/08 with diagnoses of Chronic Obstructive Pulmonary Disease, Rheumatoid Arthritis, Congestive Heart Failure, Joint Pain and Stiffness, Stage 2 Pressure Ulcer and Depression. Review of a physician's telephone order dated 9/29/10 documented, "Dec [decrease] Seroquel to 25mg [milligrams] po [by mouth] every hs [bedtime]."

The physician's recertification orders dated 10/6/10 failed to reflect the decrease of Seroquel.

During an interview at the unit 4 nurses' station on 11/16/10 at 12:15 PM, Nurse #8 and Nurse #7 reviewed Resident #11's chart. Nurse #7 stated, "The PPOC [recertification orders] has Seroquel 50mg and she is receiving Seroquel 25mg."

2. Medical record review for Resident #16 documented an admission date of 4/26/04 with diagnoses of Heart Failure, Hypertension, Diabetes Mellitus, Parkinson's Disease, Advanced Dementia, Terminal Care and Chronic Obstructive Pulmonary Disease / Emphysema. Review of a physician's telephone order dated 11/9/10 documented, "Increase O2 [oxygen] BNC [binaural cannula] to 4 LPM [liters per minute]..."
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<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>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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The physician's recertification orders dated 11/11/10 failed to reflect the increase of oxygen.  
During an interview at the unit 4 nurses' station on 11/17/10 at 10:05 AM, Nurse #8 stated, "PPOC is wrong means they did not pick up the order. Pharmacy generates the PPOC from the supplemental [orders]." | | |

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