F 164 SS=D
483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS

Requirement:
The resident has the right to, and will receive, 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 observation and interview, it was determined 2 of 9 (Nurses #2 and 7) nurses failed to provide privacy during treatment by not closing the door to the room, not closing the privacy curtain or not closing the window curtain.

ACCREDITED 4/19/12

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.

ORM CMS-2567(02-98) Previous Versions Obsolete
Event ID: IEX911
Facility ID: TN2301
If continuation sheet Page 1 of 33
Continued From page 1

The findings included:

1. Observations in Random Resident (RR) #5's room on 4/2/12 at 11:56 AM, Nurse #2 left the door to the hallway open and the door to the bathroom open with the roommate seated on the commode with full exposure.

2. Observations in Resident #6's room on 4/2/12 at 12:25 PM, Nurse #7 administered medications through Resident #6's Percutaneous Endoscopy Gastrostomy (PEG) tube. Nurse #7 failed to pull the privacy curtain, close the door to the hallway or close the window curtains. Resident #6's abdomen was exposed to anyone that passed by.

3. During an interview in the Director of Nursing's (DON) office on 4/4/12 at 3:12 PM, the DON was asked about expectations for resident's privacy during medication administration. The DON stated, "...if going to be exposed in any way, would expect them to pull privacy curtain, close the door, even if they are going to talk to them."

483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined 4 of 9 (Nurses #1, 2, 4 and 5) nurses failed to knock on the door or gain permission

Personal privacy in the bathroom is now being provided to RR #5; personal privacy is now being provided to Resident #6 during medication administration.
In-service training for nursing staff to include Nurse #1's 2, 6 and 7 was completed on 04-13-12 regarding all residents' personal privacy, to include privacy during treatment, when resident is in the bathroom, and when administering medications through PEG tube.
The QA Team, consisting of the Medical Director, Administrator, Director of Nursing, MDS Coordinator, Staffing Coordinator, Medical Records, Bookkeeper, Food Service Supervisor, Social Worker, Risk Management Nurse, Maintenance Supervisor, and Activities Coordinator, will monitor for compliance monthly for three months through random observation audits to ensure compliance. If compliance is not met, the team will re-inservice the nursing staff and continue monitoring until substantial compliance is achieved. Different members of the QA Team will participate depending on the nature of the audit.

Completion Date: 04-30-12

483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

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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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<td>F 241</td>
<td>Continued From page 2</td>
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<td>prior to entering the resident's room.</td>
<td>Requirement:</td>
<td>The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</td>
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<td>The findings include:</td>
<td>Corrective Action:</td>
<td>Nurse #1's 1, 2, 4 and 5 are now knocking on all residents' doors and gaining permission to enter prior to entering residents' rooms. Inservice training for staff to include Nurse #1's 1, 2, 4 and 5 was completed on 04-13-12 regarding the requirement of knocking on residents' doors and gaining permission to enter, prior to entering residents' rooms. The QA Team, consisting of the Medical Director, Administrator, Director of Nursing, MDS Coordinator, Staffing Coordinator, Medical Records, Bookkeeper, Food Service Supervisor, Social Worker, Risk Management Nurse, Maintenance Supervisor, and Activities Coordinator, will monitor for compliance monthly for three months through random observation audits to ensure compliance. If compliance is not met, the team will re-inservice the nursing staff and continue monitoring until substantial compliance is achieved. Different members of the QA Team will participate depending on the nature of the audit.</td>
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<td>1. Observations in the 100 hall on 4/2/12 at 11:35 AM, Nurse #1 entered Random Resident (RR) #2's room without knocking or gaining permission to enter.</td>
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<td>2. Observations in the 200 hall on 4/2/12 at 11:56 AM, Nurse #2 entered RR #5's room without knocking or gaining permission to enter.</td>
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<td>3. Observations in the 300 hall on 4/2/12 at 4:10 PM, Nurse #4 entered RR #3's room without knocking or gaining permission to enter.</td>
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<td>Observations in the 300 hall on 4/2/12 at 5:25 PM, Nurse #4 entered Resident #18's room without knocking or gaining permission to enter.</td>
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<td>4. Observations in the 400 hall on 4/2/12 at 4:20 PM, Nurse #5 entered Resident #6's room without knocking or gaining permission to enter.</td>
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<td>5. During an interview in Director of Nursing's (DON) office on 4/4/12 at 3:15 PM, the DON was asked what is the expectation of staff when entering a resident's room. The DON stated, &quot;...would expect they [staff] would knock on the door before entering a resident's room.&quot;</td>
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<td>F 280</td>
<td>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</td>
<td></td>
<td>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or</td>
<td>F 280 SS-D</td>
<td>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</td>
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Completion Date: 04-13-12

If continuation sheet Page 3 of 33
F 280: Continued From page 3
changes in care and treatment.

A comprehensive care plan must be 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.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to revise the care plan to reflect the current interventions for a tube feeding, side rails or isolation for 2 of 22 (Residents #7 and 10) sampled residents.

The findings included:


<table>
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<th>Requirement:</th>
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<tr>
<td>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</td>
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<td>A comprehensive care plan will be 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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<td>A comprehensive care plan will be 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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<td>The care plan of Resident #7 was revised on 04-04-12 to reflect the discontinuance of side rails and the correct Jevity strength.</td>
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<td>The care plan of Resident #10 was revised</td>
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<td>F280</td>
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<td>on 04-04-12 to rectify interventions for contact isolation.</td>
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<td>The care plans for all residents will be reviewed for accuracy regarding side rails, Jeivity strength and interventions for contact isolation.</td>
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<td>MDS Nurses were inserviced on 04-04-12 regarding the requirement that care plans must accurately reflect changes to side rail status, the correct Jeivity strength, and if resident is in contact isolation.</td>
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<td>The QA Team, consisting of the Medical Director, Administrator, Director of Nursing, MDS Coordinator, Staffing Coordinator, Medical Records, Bookkeeper, Food Service Supervisor, Social Worker, Risk Management Nurse, Maintenance Supervisor, and Activities Coordinator, will monitor for compliance monthly for three months through random care plan audits to ensure compliance. If compliance is not met, the team will re-inservice the nursing staff and continue monitoring until substantial compliance is achieved.</td>
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<td>Different members of the QA Team will participate depending on the nature of the audit.</td>
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<td>Completion Date: 04-13-12</td>
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F 280 Continued From page 5
a sign on the wall to go to the nurses’ station before entering the room.

Observations in Resident #10’s room on 4/2/12 at 9:25 AM, revealed a covered trash can with a red liner and a covered can for linen.

During an interview in the activity room on 4/4/12 at 7:30 AM, the Assistant Director of Nursing confirmed that Resident #10 was in isolation for *Clostridium difficile*.

F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

**483.25 PROVIDE CARE/SERVICES FOR 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 and plan of care.

This **REQUIREMENT** is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to document interventions for lack of a bowel movement (BM) for 4 of 22 (Residents #1, 2, 4 and 8) sampled residents.

The findings included:

1. Medical record review for Resident #1 documented an admission date of 5/20/10 with diagnoses of Congestive Heart Failure, Chronic Kidney Disease, Anemia and Anxiety. Review of Resident #1’s “...Bowel and Bladder by Shift
F 309: Continued From page 6

Chart had no BM documented from 1/12/12 through (-) 1/16/12 and from 2/21/12 - 2/27/12. Review of the medication administration record (MAR) for routine and as needed (PRN) medications had no laxative documented as being given when the resident failed to have a BM every three days. The facility was unable to provide documentation that a laxative had been given when lack of a BM every three days.

During an interview at the 100/200 hall nurses’ station on 4/4/12 at 8:40 AM, the Assistant Director of Nursing (ADON) was asked what was the facility's BM protocol. The ADON stated, "...on the third day of no BM... give laxative.

2. Medical record review for Resident #2 documented an admission date of 11/6/10 with a readmission date of 2/9/12 with diagnoses of Cerebrovascular Subcortical Dementia with Delusions, Parkinson's Disease and Dysphagia. Review of the physician’s standing orders, not dated, in the chart documented,


from 1/17/12 - 1/23/12; from 2/12/12 - 2/16/12; from 3/8/12 - 3/11/12; from 3/13/12 - 3/15/12; from 3/17/12 - 3/21/12; from 3/22/12 - 3/25/12 and 3/27/12 - 3/30/12. The facility was unable to provide documentation that a prn laxative was given on the third day with no BM.

Coordinator, Medical Records, Bookkeeper, Food Service Supervisor, Social Worker, Risk Management Nurse, Maintenance Supervisor, and Activities Coordinator, will monitor for compliance monthly for three months through random resident bowel movement documentation audits to ensure compliance. If compliance is not met, the team will re-inservice the nursing staff and continue monitoring until substantial compliance is achieved. Different members of the QA Team will participate depending on the nature of the audit.

Completion Date: 04-30-12
**F 309** Continued From page 7

During an interview at the 100/200 hall nurses' station on 4/3/12 at 10:50 AM, Nurse #1 was asked what she would do for a resident who had not had a BM for three days and how she would know a resident had not had a BM for several days. Nurse #1 stated, "...she [Resident #2] gets stool softener every day... check the caretracker... medicate with pm laxative on the third day..."

3. Medical record review for Resident #4 documented on admission date of 6/17/10 with diagnoses of Cardiopulmonary Obstructive Disease, Parkinson Disease, Depression and Anxiety. Review of Resident #4's "...Bowel and Bladder by Shift Chart..." had no BM documented from 1/1/12 - 1/3/12 and from 1/5/12 - 1/7/12. Review of the MAR for routine and PRN medications had no laxative documented as being given when the resident failed to have a BM every three days.

During an interview at the 300/400 hall nurses' station on 4/4/12 at 1:35 PM, the ADON was asked what was the facility's BM protocol. The ADON stated, "...goes on her [Resident #4] own and the Certified Nursing Assistants (CNA) need to ask her [Resident #4] and chart, after 3 shifts (3 days) we go to standing orders."

4. Medical record review for Resident #8 documented an admission date of 9/18/09 with a readmission date of 1/16/12 with diagnoses of Depression, Hypertension, Diabetes Mellitus, Anxiety, Osteoporosis, Urinary Tract Infection, Advanced Dementia and Polymyalgia. Review of the physician's standing orders dated 3/21/12 documented, "...CONSTIPATION: Once Daily:"
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<td>F 309</td>
<td>Continued From page 8</td>
<td>MOM 30cc po PRN; or Bisacodyl 10mg. supp. p.r. PRN or Bisacodyl 5mg. tab po PRN... &quot;Review of Resident #8's &quot;...Bowel and Bladder by Shift Chart...&quot;, dated January 2012, February 2012 and March 2012 had no BM documented on the following dates: from 1/17/12 - 1/20/12; from 1/27/12 - 1/30/12; from 2/1/12 - 2/5/12; from 2/18/12 - 2/22/12 and from 3/16/12 - 3/19/12. The facility was unable to provide documentation that a prn laxative was given on the third day with no BM. During an interview at the 300/400 hall nurses' station on 4/3/12 at 10:35 AM, Nurse #6 was asked what she would do for a resident who had not had a BM for three days and how she would know a resident had not had a BM for several days. Nurse #6 stated, &quot;...medicate prn... she [Resident #8] doesn't like the taste of Lactulose... give suppository when she needs it... we check caretracker and husband tells us when she needs it...&quot; Nurse #6 was asked when she would give a laxative. Nurse #6 stated, &quot;...on the third day with no BM...&quot; 5. During an interview in the Director of Nursing's (DON) office on 4/3/12 at 11:25 AM, the DON was asked what she would expect the nurse to do for residents who failed to have a BM for three or more days. The DON stated, &quot;...expect nurses to treat to relieve constipation... believe residents receive laxative on the third day without a BM... use our protocol... standing orders...&quot; The DON was asked how the nurses knew the residents had not had a BM. The DON stated, &quot;...caretracker... each charge nurse pulls up a 9 shift report every morning... beginning of shift...&quot;</td>
<td>F 309</td>
<td>483.25(d) NO CATHETER, PREVENT UTI,</td>
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F 315 SS=D 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

Requirement:
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.

Corrective Action:
The facility will ensure perineal and foley care is performed according to "Long-Term Pocket Guide for Infection Control" guidelines for all indicated residents, to include Resident #5.
Resident #5 has been assessed for any signs and symptoms that may have resulted from improper perineal and foley care technique. Inservice training for Certified Nursing Assistants (CNA's) to include CNA #5 was completed on 04-13-12 regarding the performance of perineal and foley care according to these guidelines.

Observations in Resident #5's room on 4/3/12 at 3:20 PM, Certified Nursing Assistant (CNA) #5 washed her hands and donned gloves, positioned Resident #5's left leg. CNA #5 proceeded to perform foley catheter care without changing gloves.

Based on the resident's comprehensive assessment, the facility will 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 review of "Long-Term Pocket Guide for Infection Control," observation and interview, it was determined the facility failed to ensure perineal and foley care was performed according to guidelines for 1 of 4 (Resident #5) sampled residents observed receiving perineal care.

The findings included:
Review of the "Long-Term Pocket Guide for Infection Control," section 2, page 50 documented, "...Decontaminate hands if moving from a contaminated-body site to a clean-body site during resident care..."

Observations in Resident #5's room on 4/3/12 at 3:20 PM, Certified Nursing Assistant (CNA) #5 washed her hands and donned gloves, positioned Resident #5's left leg. CNA #5 proceeded to perform foley catheter care without changing gloves.
### F 315: Continued From page 10

During an interview in the Director of Nursing’s (DON) office on 4/4/12 at 10:10 AM, the DON was asked if a CNA touched a body part not involved in cleaning prior to perineal / foley care what should be done. The DON stated, "...expected that if any area of the body was touched she would expect them to remove their gloves, wash her hands and reglo..."

### F 328

#### SS= D

**483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS**

The facility must ensure that residents receive proper treatment and care for the following 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, observation and interview, it was determined the facility failed to ensure proper care of a Peripherally Inserted Central Catheter (PICC) line for 1 of 1 (Resident #5) sampled residents with a PICC line.

The findings included:

Medical record review for Resident #5 documented an admission date of 9/28/10 with a readmission date of 3/17/12 with diagnoses of Anxiety, Depression, Recurrent Urinary Tract...
**F 328** Continued From page 11

Infection, Decubitus Ulcer Stage III, Chronic Renal Failure, Hypertension, Congestive Heart Failure, Neurogenic Bladder and PICC. Review of physician's orders dated 3/23/12 documented, "...When picc is not in use, keep wrapped in kerlix to prevent (p) [patient] from pulling it out." Review of the care plan dated 3/23/12 documented, "may apply protective wrap of kerlix to prevent res. [resident] from pulling out picc line."

Observations in Resident #5's room on 4/2/12 at 10:30 AM, on 4/3/12 at 8:00 AM and 3:20 PM, revealed the area of the PICC line was not wrapped with a kerlix as ordered.

During an interview in the activities office on 4/4/12 at 2:10 PM, the Assistant Director of Nursing (ADON) was asked if there was an order for the PICC line to be wrapped with kerlix did she expect it to be wrapped. The ADON stated, "Yes."

**F 441**

483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

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.

(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

Food Service Supervisor, Social Worker, Risk Management Nurse, Maintenance Supervisor, and Activities Coordinator, will monitor for compliance monthly for three months through random observation audits to ensure compliance. If compliance is not met, the team will re-inservice the nursing staff and continue monitoring until substantial compliance is achieved. Different members of the QA Team will participate depending on the nature of the audit.

Completion Date: 04-30-12

**F 441**

483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

**Requirement:**
The facility will 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.

**Corrective Action:**
The facility will insure practices are maintained to prevent the spread of infection regarding sanitary hand hygiene, wearing...
Continued From page 12

(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 infection.

This REQUIREMENT is not met as evidenced by:
Based on policy review, review of a product information, Association of Practitioners of Infection Control (APIC) guidelines, observation and interview, it was determined the facility failed to ensure practices were maintained to prevent the spread of infection when 8 of 9 certified nursing assistants (CNA #1, 2, 3, 4, 6, 7, 8 and 9) failed to practice sanitary hand hygiene or failed to wear appropriate personal protective equipment for isolation precautions and 5 of 9 nurses (Nurses #1, 2, 3, 4 and 7) failed to practice sanitary hand hygiene, failed to clean the appropriate personal protective equipment of isolation precautions, the cleaning of glucometers with the required disinfectant and the sanitization of stethoscopes between residents.

Inservice training for Certified Nursing Assistants staff, to include CNA #’s 1, 2, 3, 4, 6, 7, 8 and 9, was completed on 04-13-12 regarding proper sanitary hand hygiene requirements and wearing appropriate personal protective equipment for isolation precautions. Inservice training for nursing staff, to include Nurse #’s 1, 2, 3, 4 and 7, was completed on 04-13-12 regarding proper sanitarian hand hygiene, the proper cleaning of glucometers with the required disinfectant, and the sanitization of stethoscopes between residents.

Inservice training for Floor Maintenance and Housekeeping staff was completed on 04-13-12 regarding the requirement to clean isolation rooms with chlorine-based disinfectant.

The QA Team, consisting of the Medical Director, Administrator, Director of Nursing, MDS Coordinator, Staffing Coordinator, Medical Records, Bookkeeper, Food Service Supervisor, Social Worker, Risk Management Nurse, Maintenance Supervisor, and Activities Coordinator, will monitor for compliance monthly for three months through random observation audits to ensure compliance. If compliance is not met, the team will re-inservice the nursing staff and continue monitoring until substantial compliance is achieved.

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The findings included:

1. Observations in the 300 hall on 4/2/12 at 11:50 AM, CNA #1 placed a meal tray on bedside table, removed the lid, placed a clothing protector on the resident, then raised the head of bed up with bare hands on crank then held a glass of tea and a straw to the resident's mouth, she then washed her hands and turned off the water with bare hands.

2. Observations in the 300 hall on 4/2/12 at 5:30 PM, CNA #2 brought a meal tray into a room, washed her hands and turned the water off with her bare hands. CNA #2 then brought a meal tray to another room, washed her hands and turned the water off with her bare hands.

Observations in the 300 hall on 4/2/12 at 5:35 PM, CNA #2 brought the meal tray to a room, washed her hands and turned off the water with her bare hands.

3. Observations in the 300 hall on 4/2/12 at 5:55 PM, CNA #3 brought a meal tray to room, washed her hands and turned the water off with her bare hands.

4. Observations in the 100 hall dining room on 4/2/12 at 6:15 PM, CNA #4 placed a clothing protector on a resident, set up the meal tray, returned to the tray cart and removed a tray and set up the tray for another resident. CNA #4 failed to perform hand hygiene between residents.
5. Observations in the 200 hall on 4/2/12 at 12:15 PM, CNA #6 entered an isolation room with a meal tray without applying gloves, used hand gel to cleanse hands, then came back into the hallway to the tray cart for a clothing protector and returned to the isolation room without applying gloves.

6. Observations in the 200 hall on 4/2/12 at 6:25 PM, CNA #7 and CNA #8 entered the isolation room without applying gloves. CNA #7 and CNA #8 pulled Resident #10 up in bed, then CNA #7 set up the tray without applying personal protective equipment.

7. Review of the facility's "Isolation" policy documented, "...EQUIPMENT AND SUPPLIES...
   1. Placement of equipment and supplies...
      b. Inside room... blood pressure cuff and stethoscope... Contact Precautions... Dedicate the use of equipment such as stethoscopes or thermometers to a single patient or cohort..."

   Review of facility's product information sheet for "OxyFECT" and "PH7Q Ultra" documented no activity against the clostridium difficile organism.

   Review of the APIC "Guide to the Elimination of Clostridium difficile In Healthcare Settings" documented, "...Disinfectants commonly used in healthcare settings include quaternary ammoniums and phenolics, neither of which are sporicidal... only chlorine-based disinfectants... kills spores..."

   Observations on the 200 hall on 4/2/12 at 4:10 PM, CNA #9 came out of the isolation room with
F 441 Continued From page 15

blood pressure machine. The resident was in isolation for the organism clostridium difficile.

During an interview in the 200 hall on 4/2/12 at 4:11 PM, CNA #9 was asked if she had used the blood pressure machine on both of the residents in the room. CNA #9 stated, "...yes, I take vital signs on all of the skilled residents..." CNA #9 used the same blood pressure machine on multiple residents without disinfecting the machine.

During an interview in the activity office on 4/4/12 at 7:30 AM, the Assistant Director of Nursing (DON) was asked if the resident in isolation had his own equipment. The ADON stated, "...yes, I saw [named CNA #9] come out of the isolation room yesterday and I asked her if she had wiped the blood pressure machine down and she [CNA #9] told me that she didn't.

During an interview by the janitor closet on 100 hall on 4/4/12 at 2:25 PM, a Floor Maintenance staff was asked what they used to clean isolation rooms. The staff member stated, "...don't use anything different we just change the water more frequently...

During an interview in the activity office on 4/4/12 at 2:40 PM, the Administrator was asked what the facility used to clean isolation rooms. The Administrator stated, "The facility uses OxyFect on surfaces and PH7 Q Ultra on floors..."

8. Review of the facility's "Proper Technique For Cleaning Glucometers" policy documented, "...We use PDI Super Sani cloths-Takes 2 minutes to dry... Glucometers must be cleaned
Continued From page 16 before and after each use."

a. Observations outside Random Resident (RR) #2's room on 4/2/12 at 11:35 AM, Nurse #1 cleaned the glucometer with a Sani cloth that contained no bleach.

b. Observations outside RR #6's room on 4/2/12 at 12:00 PM, Nurse #2 cleaned the glucometer with a Sani cloth that contained no bleach. Nurse #2 touched the towel holder with wet, bare hands.

9. Observation in RR #1's room on 4/2/12 at 5:05 PM, Nurse #3 administered eye drops in RR #1's left and right eye then used the same tissue to wipe both eyes. Nurse #3 washed hands then touched the towel holder with wet, bare hands. Nurse #3 then picked dirty towels off floor. Nurse #3 did not wash her hands after picking up dirty towels.

10. Observations in Resident #18's room on 4/2/12 at 5:25 PM, Nurse #4 placed the glucometer on the bedside table without a barrier and administered insulin without gloves.

Observation in RR #3's room on 4/2/12 at 4:10 PM, Nurse #4 administered eye drops without applying gloves.

11. Observation in Resident #6's room on 4/2/12 at 12:25 PM, Nurse #7 pulled a plunger from a syringe, placed the plunger on the bed without a barrier. Nurse #7 placed the stethoscope on Resident #6's abdomen and then placed stethoscope around her neck. Nurse #7 washed her hands and touched the towel holder with her wet, bare hands. Nurse #7 failed to clean
F 441 | Continued From page 17
| stethoscope before or after use on resident.

F 504
| SS=D

483.75(i)(2)(i) LAB SVCS ONLY WHEN
ORDERED BY PHYSICIAN

The facility must provide or obtain laboratory services only when ordered by the attending physician.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review and interview, it was determined the facility failed to obtain blood samples for laboratory (lab) tests only when ordered by the physician for 1 of 22 (Resident #13) sampled residents.

The findings included:

Review of the "Lab or Special Tests" policy documented, "...1. Must have physician's order signed and dated for specific lab work or test...."

Medical record review for Resident #13 documented an admission date of 6/20/11 with diagnoses of Neurogenic Bladder, Hypertension, Stage II Sacral Decubitus Ulcer, Arthritis and Renal Insufficiency. Review of the physician's orders dated 2/2/12 documented no orders for labs. Review of the physician's orders dated 3/5/12 documented,..."CBC [complete blood count], BMP [basic metabolic panel] now..." Review of a physician's telephone order dated 3/5/12 documented,..."CBC, BMP, Wt. [weight] Q [every] wk. [week] x [times] 4 wks [weeks]." Review of the lab results documented labs being done on the following dates: 2/8/12 - CBC and complete metabolic panel (CMP); 3/5/12 - CBC

F 504
| SS=D

483.75(i)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN

Requirement:
The facility will provide or obtain laboratory services only when ordered by the attending physician.

Corrective Action:
The facility will provide or obtain laboratory services for Resident #13 and for all residents only when ordered by the attending physician.

Inservice training for nursing staff was completed on 04-13-12 regarding the requirement that the facility will provide or obtain laboratory services only when ordered by the attending physician.

The QA Team, consisting of the Medical Director, Administrator, Director of Nursing, MDS Coordinator, Staffing Coordinator, Medical Records, Bookkeeper, Food Service Supervisor, Social Worker, Risk Management Nurse, Maintenance Supervisor, and Activities Coordinator, will monitor for compliance monthly for three months through random laboratory services audits to ensure compliance. If compliance is not met, the team will re-inservice the nursing staff and continue monitoring until substantial compliance is achieved.

Different members of the QA Team will participate depending on the nature of the audit.

Completion Date: 04-30-12
F 504: Continued From page 18
and CMP; 3/19/12 - CBC and BMP; 3/26/12 - CBC and BMP and 4/2/12 - CBC and BMP.

During an interview at the 100/200 hall nurses' station on 4/3/12 at 2:30 PM, the Assistant Director of Nursing (ADON) was asked about the order for the CBC and BMP drawn on 3/19/12, 3/26/12 and 4/2/12. The ADON stated, "...probably misinterpreted the [3/5/12] order..." The ADON confirmed the 3/5/12 order was a one time order for the CBC and BMP.

During an interview in the activity office on 4/4/12 at 7:40 AM, the ADON was asked why a CMP was drawn on 3/5/12 instead of the BMP that was ordered. The ADON stated, "...She [the nurse] marked a CMP instead of a BMP [on the lab requisition]..."The ADON was asked for the order for the 2/9/12 CBC and BMP. The ADON stated, "...failed to take it off the draw list when order changed."

F 514: 483.75(1)(1) RES
SS=E RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident 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; and progress notes.
**Corrective Action:**

The facility will maintain medical records that are complete and accurate by documenting on routine and as needed (PRN) medication records, treatment records, and will reconcile the physician’s orders for all residents, to include Resident #’s 1, 5, 6, 7, 9, 11, 12, 13, and 15, and Random Resident #4.

A chart audit will be performed for these and all residents to ensure that routine and PRN medication records, treatment records, and the reconciliation of physician’s orders are correct.

Inservice training for nursing staff was completed on 04-13-12 regarding the requirement to document routine and PRN medication records, treatment records, and the reconciliation of physician’s orders.

The QA Team, consisting of the Medical Director, Administrator, Director of Nursing, MDS Coordinator, Staffing Coordinator, Medical Records, Bookkeeper, Food Service Supervisor, Social Worker, Risk Management Nurse, Maintenance Supervisor, and Activities Coordinator, will monitor for compliance monthly for three months through random chart audits to ensure compliance. If compliance is not met, the team will re-inservice the nursing staff and continue monitoring until substantial compliance is achieved.

Different members of the QA Team will participate depending on the nature of the audit.

**Completion Date:** 04-30-12
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vital signs and treatments were not initialed as being done:

a. "...lorazepam 0.5 mg [milligram] TABS [tablets]...ONE HALF TAB...BY MOUTH TWO TIMES DAILY... 9:00 AM... 4:00 PM..." There were no initials indicating the lorazepam had been given on 1/25/12 at 9:00 AM and 4:00 PM, on 2/20/12 at 4:00 PM and on 2/21/12 at 9:00 AM and 4:00 PM.

b. "...METAZOLONE-5MG- TABS...TAKE ONE TAB BY MOUTH EVERY DAY... 8:30 AM..." There were no initials indicating the metazozone had been given on 1/29/12 and 2/21/12 at 8:30 AM.

c. "...POTASSIUM CL [chloride] 10MEQ [milliequivalents] ER [extended release] CAP [capsule]...ONE CAPSULE BY MOUTH EVERY DAY... 9:00 AM. There were no initials indicating the potassium chloride had been given on 1/29/12 and 2/21/12 at 9:00 AM.

d. "...SENNA TAB [tablet] 8.0MG [milligrams]...ONE BY MOUTH TWO TIMES DAILY... 9:00 AM... 4:00 PM..." There were no initials indicating the senna had been given on 1/29/12 at 9:00 AM, 2/20/12 at 4:00 PM and on 2/21/12 at 9:00 AM and 4:00 PM.

e. "...Z [zithromycin] pack as directed x [time] 5 days... 4 pm..." There were no initials indicating the Z pack had been given on 1/29/12 at 4:00 PM.

f. "...SKIN AUDIT WEEKLY... Mon [Monday]..." There were no initials indicating a skin audit had been done on 1/1/12, 1/9/12, 1/16/12, 1/23/12, 1/30/12, 2/6/12, 2/13/12, 2/20/12 and 2/27/12.

g. "...CITALOPRAM TAB 20MG...TAKE ONE TAB BY MOUTH AT BEDTIME... 9:00 PM..." There were no initials indicating the citalopram had been given on 3/26/12 and 3/27/12 at 9:00
**F514** Continued From page 21

PM.

h. "...FERROUS SULF [sulfate] TAB 325MG... ONE BY MOUTH TWO TIMES DAILY... 9:00 AM... 4:00 PM..." There were no initials indicating the ferrous sulfate had been given on 3/26/12 and 3/27/12 at 4:00 PM.

There were no indications in the record as to why the medications and skin audits were not documented.

During an interview at the 100/200 hall nurses' station on 4/4/12 at 8:45 AM, the Assistant Director of Nursing (ADON) confirmed the January 2012, February 2012 and March 2012 routine medication and treatment records were incomplete for Resident #1.

3. Medical record review for Resident #5 documented an admission date of 9/28/10 with a readmission date of 3/17/12 with diagnoses of Anxiety, Depression, Recurrent Urinary Tract Infection, Decubitus Ulcer Stage III, Chronic Renal Failure, Hypertension, Congestive Heart Failure, Neurogenic Bladder, PICC Line. Review of the routine medication and treatment records for January, February and March 2012, revealed the following medications and treatments were not initialed as being done:

a. "....ALPRAZOLAM 0.5MG TABLETS... ONE BY MOUTH EVERY MORNING... 9:30 AM..." There were no initials indicating the medication was given on 1/17/12 at 9:30 AM.

b. "....ALPRAZOLAM 1MG TABS... ONE BY MOUTH AT BEDTIME... 8:00 PM..." There were no initials indicating the medication was given on 1/24/12, 2/5/12, 2/10, 2/21/12, 2/28/12 and 2/29/12 at 8:00 PM.

c. "....AMIODARONE HCL [hydrochloride] 200MG..."
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:** 445446

**A. BUILDING:**

**B. WING:**

**DATE SURVEY COMPLETED:** 04/04/2012

**NAME OF PROVIDER OR SUPPLIER:**

DYERSBURG MANOR NURSING HOME

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

1900 PARR AVENUE
DYERSBURG, TN 38024

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<tr>
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**F 514**

- TABS... ONE TAB BY MOUTH AT BEDTIME...
- 8:00 PM..." There were no initials indicating the medication was given on 1/24/12, 2/1/12, 2/3/12 and 2/11/12 and there was no pulse documented as being taken on 1/8/12 and 1/24/12.
- d. "...CARVEDILOL TAB 3.125MG... ONE TABLET BY MOUTH TWO TIMES DAILY... 9:30 AM... 4:15 PM." There were no initials indicating the medication had been given on 1/17/12 at 9:30 AM and 1/24/12 and 2/20/11 at 4:15 PM.
- e. "...FLUOXETINE CAP 20MG... ONE CAPSULE BY MOUTH EVERY DAY... 9:30 AM." There were no initials indicating the medication was given on 1/17/12 at 9:30 AM.
- f. "...LASIX TAB 20MG THREE (60MG)... BY MOUTH EVERY MORNING... 9:30 AM." There was no initials indicating the medication had been given on 1/17/12 at 9:30 AM.
- g. "...GABAPENTIN CAP 300MG... ONE BY MOUTH THREE TIMES DAILY... 1:00 PM...
- 4:15PM." There were no initials indicating the medication had been given on 1/2/12, 1/3/12, 2/22/12 and 2/28/12 at 1:00 PM and on 3/7/12 and 3/9/12 at 4:15 PM.
- h. "...OXYBUTYNIN CHLORIDE 5MG TABS... BY MOUTH EVERY MORNING... 9:00 AM." There were no initials indicating the medication had been given on 1/17/12 at 9:00 AM.
- i. "...POLETHY [polyethylene] GLYC [glycol] POW [powder] 3350 17GM [gm]... DILUTED IN 8 OUNCES OF H2O [water] OR JUICE EVERY DAY." There were no initials indicating the medication had been given on 1/19/12.
- j. "...POTASSIUM CHLORIDE 20MEQ... TAKE ONE TAB EVERY DAY." There were no initials indicating the medication had been given on 1/17/12.
- k. "...STRESS FORM/TAB ZINC... ONE TABLET
Continued From page 23

BY MOUTH EVERY DAY..." There were no initials indicating the medication had been given on 1/17/12.

l. "...TRAMADOL... ONE BY MOUTH TWO TIMES DAILY... 8:30 AM... 4:00 PM..." There were no initials indicating the medication had been given on 1/17/12 at 8:30 AM and 1/26/12 at 4:00 PM.

m. "...GABAPENTIN CAP 400MG... BY MOUTH THREE TIMES A DAY..." There was no initial indicating the medication had been given on 1/17/12, 1/22/12 and 1/25/12 at 4:00 PM.

n. "...DIGOXIN 0.625MG... ONE BY MOUTH EVERY DAY - CHECK PULSE..." There were no initials indicating the pulse was obtained on 2/20/12, 2/23/12 and 3/31/12.

There were no weekly skin audits documented in January, February and March, 2012.

4. Medical record review for Resident #6 documented an admission date of 12/8/09 with diagnoses of Congestive Heart Failure, Hemiplegia, Traumatic Brain Injury and Percutaneous Gastrostomy tube (PEG). The January and February, 2012 weekly skin audits had no initials indicating weekly skin audits were done. Review of the March 2012 weekly skin audits revealed there was only 2 of 4 weekly skin audits done on 3/8/12 and 3/20/12.

5. Medical record review for Resident #7 documented an admission date of 3/12/09 with diagnoses of Cerebrovascular Accident, Seizures, Depression and Dysphagia. Review of the routine and PRN medication and treatment records for January, February and March, 2012 revealed the following medications, vital signs and treatments were not initialed as being done:
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a. "...Labetalol 300 mg 1 per peg TID... 4 am ...10 am ... 5p..." There were no initials indicating the labetalol had been given on 1/5/12, 1/15/12, 1/24/12, 1/28/12, 1/29/12 at 5:00 PM, on 1/25/12, 1/26/12, 1/27/12 at 10:00 AM, on 1/28/12, 1/29/12 at 5:00 PM, on 1/30/12, 2/1/12, 2/15/12, 2/26/12, 2/27/12 at 10:00 AM, on 2/28/12, 2/29/12 at 5:00 PM, on 3/1/12, 3/16/12, 3/25/12 at 10:00 AM, and on 3/21/12, 3/22/12, 3/24/12, 3/25/12 at 5:00 PM.

b. "...Labetalol 300 mg 1 per peg TID... Hold for SBP [systolic blood pressure] or HR [heart rate] < [less than] 55 ... 4 am ... 10 am ... 5p..." There were no initials indicating the blood pressure had been checked on 1/10/12 at 4:00 AM, on 1/5/12, 1/14/12, 1/15/12, 1/24/12, 1/28/12, 1/29/12 at 10:00 AM, on 2/1/12, 2/2/12, 1/15/12, 1/22/12, 1/26/12 through 1/31/12 at 5:00 PM. There were no initials indicating the HR had been taken on 2/1/12 through 2/14/12, 2/16/12, 2/18/12, 2/21/12, 2/23/12, 2/27/12 at 4:00 AM, on 2/10/12, 2/11/12, 2/17/12, 2/21/12, 2/25/12 through 2/29/12, on 3/6/12, 3/16/12, 3/25/12, 3/31/12 at 10:00 AM, on 3/4/12, 3/6/12, 3/8/12, 3/15/12, 3/20/12, 3/26/12, 3/30/12 at 4:00 AM, on 3/6/12, 3/16/12, 3/25/12, 3/31/12 at 10:00 AM, and on 3/2/12 through 3/8/12, 3/13/12 through 3/22/12, 3/24/12 through 3/28/12, 3/30/12 and 3/31/12 at 5:00 PM.

c. "...SKIN AUDIT WEEKLY... Sat [Saturday]..." There were no initials indicating a skin audit had been done on 1/7/12, 1/14/12, 1/21/12, 1/28/12, 2/4/12, 2/11/12, 2/18/12 and 2/25/12.

There were no indications in the record as to why the medications, vital signs and skin audits were not documented as being done.

During an interview at the 100/200 hall nurses' station on 4/4/12 at 8:45 AM, the ADON
F 514 Continued From page 25
confirmed the January 2012, February 2012 and March 2012 routine medication and treatment records were incomplete for Resident #7.

6. Medical record review for Resident #9 documented an admission date of 3/3/10 with a diagnoses of Cognitive Impairment, Psychosis, Hypothyroidism, Gastroesophageal Reflux Disease. Review of the January, February and March, 2012 routine and PRN medication and treatment records revealed the following medications, vital signs and treatments were not initiated as being done:
   a. "...ATELVIA-325MG-TABLET EC [enteric coated] ONE BY MOUTH EVERY 7 DAYS ON THURSDAY... 6:00 AM..." There were no initials indicating the atelvia had been given on 2/16/12 at 6:00 AM.
   b. "...DOCUSATE CALCIUM 240 MG CAPS ONE TWO TIMES DAILY... 9:00 AM... 4:00 PM..." There were no initials indicating the docusate calcium had been given on 1/10/12 at 9:00 AM, on 1/14/12 at 4:00 PM, on 1/15/12 at 9:00 AM and 4:00 PM, on 1/22/12 at 4:00 PM, on 1/28/12 at 4:00 PM, on 1/29 at 9:00 AM and 4:00 PM, on 2/22/12 at 4:00 PM, on 2/27/12 at 9:00 AM and 3/18/12 at 9:00 AM.
   c. "...LEVOTHYROXIN TAB 150 MICROGRAMS [mcg] TAKE ONE TAB BY MOUTH EVERY DAY... 4:00 PM..." There were no initials indicating the levothyroxin had been given on 1/15, 1/22/12, 1/28/12 and 1/29/12 at 4:00 PM.
   d. "...MIRTAZAPINE... 15 MG TAB ONE BY MOUTH AT BEDTIME... 8:00 PM..." There were no initials indicating the mirtazapine had been given on 1/10/12, 1/22/12 and 3/2/12 at 8:00 PM.
   e. "...OYST [oyster] /CAL [calcium] D 500/200 TAB TAKE ONE TAB BY MOUTH TWO TIMES
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DAILY... 9:00 AM... 4:00 PM...” There were no initials indicating the cystic fluid had been given on 1/10/12, 1/22/12, 1/28/12, 1/29/12 at 8:00 PM and on 2/27/12 and 3/16/12 at 9:00 AM.

f. "...RISPERIDONE TAB 0.5 MG ONE BY MOUTH AT BEDTIME... 8:00 PM..." There were no initials indicating the risperdone had been given on 1/22/12 at 8:00 PM.

g. "...LACTINEX 2 PO [by mouth] PO THREE X [times] 5 DAYS... 9:00 AM, 4:00 PM and 8:00 PM..." There were no initials indicating the lactinex had been given on 2/26/12 at 9:00 AM and 4:00 PM and on 2/27/12 at 9:00 AM.

h. "...DUONEBS INH [inhaled] TID X 10 D [days]... 9:00 AM... 4:00 PM..." There were no initials indicating the duonebs had been given on 2/26/12 at 9:00 AM and 4:00 PM and on 2/27/12 at 9:00 AM.

i. "...CHECK BLOOD PRESSURE EVERY WEEK ON SUNDAY... 7:00 AM- [to] 3:00 PM [shift]..." There were no initials indicating the blood pressure checks were done on 1/15/12, 1/28/12, 2/12/12, 2/26/12 and 3/18/12.

j. "...SKIN AUDIT WEEKLY... THUR [THURSDAY]..." There were no initials indicating a skin audit had been done on 1/3/12, 1/5/12, 1/12/12, 1/19/12, 1/26/12, 2/2/12, 2/9/12, 2/16/12, 2/23/12 and 3/8/12.

There were no indications in the record as to why the medications, blood pressures and skin audits were not documented as being done.

7. Review of the facility's "...Reconciliation Process" policy documented, "Each patient's Recertification / Physician Order Form must be reconciled starting from the last Recertification / Physician Order Form until the present orders regardless of whether a physician visit is due for
that patient... The practice of having the same nurse(s) responsible for this process will promote ownership of the accuracy of the recerts [recertifications]."

Medical record review for Resident #11 documented an admission date of 2/17/12 and a readmission date of 3/11/12 with diagnoses of Acute Renal Failure, Congestive Heart Failure, Digoxin Toxicity, Urinary Tract Infection, Diabetes Mellitus, Respiratory Failure, Chronic Obstructive Pulmonary Disease, Depression and Psychosis. Review of the physician's orders dated 3/31/12 documented, "...USE # [number] 16 FR [french] / 5CC [cubic centimeters] BULB FOLEY CATHETER..." Review of the routine medication records revealed the following medications were given: Z pack take as directed, Zyrtec 10mg po daily, Novolog 6 units before meals (ac), Levothyroxine 200 mcg 1 po daily, Metoprolol extended release (ER) 12.5 mg po daily, Plavix 75 mg 1 po daily, Potassium Chloride 10 meq 1 po twice a day (BID), Risperdal 2 mg po every (Q) hour of sleep (hs), Requip 0.25 mg po every day (qd), Spiriva inhaler 1 puff 18 mcg Q hs, Theophylline 200 mg 1 po daily, Trazadone 150 mg po Q hs, Magnesium Oxide 400 mg po BID, Colace 100 mg po BID, Loratab 10/650 mg 1 po four times a day (QID), Xanax 1 mg po TID PRN medications and fingerstick blood sugar accucheks were performed before meals. There was no documentation these 17 medications and accucheks were included on the current physician's recertification orders dated 3/31/12.

Observations in Resident #11's room on 4/2/12 at 9:10 AM, revealed Resident #11 did not have a Foley catheter.
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During an interview at the nurses' station, on 4/2/12 at 4:05 PM, Nurse #8 confirmed there was only one original physician's orders and she was unable to locate the further orders.

During an interview in the Director of Nursing's (DON) office, on 4/3/12 at 3:05 PM, the DON verified the physician's orders were missing.

During an interview in the activity office on 4/4/12 at 7:25 AM, the DON confirmed the physician's order for a Foley catheter should not have been continued and that she was unable to locate the original physician orders.

8. Medical record review for Resident #12 documented an admission date of 2/15/12 with diagnoses of Fracture Right Wrist, Fracture Right Knee Cap, Fracture Left Shoulder, Hypertension, Diabetes Mellitus and Osteoarthritis. Review of the March 2012 treatment records revealed the following treatments were not initialed as being done:
   a. "...SKIN AUDIT WEEKLY..." There were no initials indicating the weekly skin audits were done.
   b. "...clean buttocks and inner glutes c [with] soap & [and] water apply Mazo Bid [two times a day] & PRN..." There were no initials for the 7-3 (shift) on 3/17, 3/18 and 3/19 or for the 11-7 (shift) on 3/25 and 3/26 indicating the treatment was done.

During an interview outside the DON's office on 4/4/12 at 1:50 PM, the DON was asked where the weekly skin audits were documented on the March 2012 treatment record. The DON stated, "...they [nurses] didn't document the skin audits..."
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9. Medical record review for Resident #13 documented an admission date of 6/20/11 with diagnoses of Neurogenic Bladder, Hypertension, Stage II Sacral Decubitus Ulcer, Arthritis and Renal Insufficiency. Review of the January 2012, February 2012 and March 2012 routine and PRN medication and treatment records revealed the following medications, vital signs and treatments were not initialed as done:
   a. "...AMLODIPINE 5 MG... ONE TABLET BY MOUTH EVERY DAY... 9:00 AM..." There were no initials indicating the amiodipine had been given on 3/4/12 at 9:00 AM and 4:00 PM and on 3/7/12 at 4:00 PM.
   b. "...DONEPEZIL TAB 10 MG... TAKE ONE TAB AT BEDTIME... 8:00 pm..." There were no initials indicating the donepezil had been given on 3/2/12 and 3/7/12 at 8:00 PM.
   c. "...LUMIGAN 0.03 % [percent] OPTH [ophthalmic] SOL [solution] 2.5 MLS [milliliters]... ONE DROP BOTH EYES AT BEDTIME... 8:00 PM..." There were no initials indicating the lumigan had been given on 3/6/12, 3/20/12 and 3/27/12 at 8:00 PM.
   d. "...VITAMIN D TAB 1000 UNIT ONE TWO TIMES DAILY... 9:00 AM... 4:00 PM..." There were no initials indicating the vitamin d had been given on 3/4/12 at 9:00 AM and 3/25/12 at 4:00 PM.
   e. "...SKIN AUDIT WEEKLY... 3-11 ON Friday..." There were no initials indicating a weekly skin audit had been done on 2/3/12, 2/10/12, 2/17/12 and 2/24/12 and on 3/9/12, 3/23/12 and 3/30/12. There were no indications documented as to why the medications and skin audits were not documented as being done.
F 514. Continued From page 30

During an interview at the 100/200 hall nurses' station on 4/4/12 at 8:45 AM, the ADON confirmed the January, February and March 2012 routine medication and treatment records were incomplete for Resident #13.

10. Medical record review for Resident #15 documented an admission date of 4/29/08 with a diagnoses of Metabolic Encephalopathy, Dilantin Toxicity, Dementia. Review of the January, February and March 2012 routine medication and treatment records revealed the following medications, vital signs and treatments were not initialed as done:

a. "...ALIGN CAP [capsule] 4 MG ONE BY MOUTH EVERYDAY... 10:00 AM..." There were no initials indicating the align had been given on 2/27/12 at 10:00 AM.

b. "...FUROSEMIDE TAB 20 MG TAB BY MOUTH EVERY MORNING... 10:00 AM..." There were no initials indicating the furosemide had been given on 2/27/12 at 10:00 AM.

c. "...CHILD ASA [aspirin] CHW [chewable] 81 MG ONE TAB BY MOUTH EVERY MORNING... 10:00AM..." There were no initials indicating the child asa had been given on 2/27/12 at 10:00 AM.

d. "...OMEPRAZOLE CAP 20 MG ONE CAPSULE EVERY DAY... 10:00 AM..." There were no initials indicating the omeprazole had been given on 1/15/12 and 3/27/12 at 10:00 AM.

e. "...OXYBUTYNIN ER 150 MG TABS TAKE ONE TAB BY MOUTH EVERY DAY... 10:00 AM..." There were no initials indicating the oxybutynin had been given on 1/15/12 and 1/27/12 at 10:00 AM.

f. "...OYST-CA-D TAB 500 MG ONE TAB BY MOUTH THREE TIMES DAILY... 10:00 AM... 4:00PM... 8:00 PM..." There were no initials...
Continued From page 31

indicating the oyst-ca-d had been given on 1/5/12 at 8:00 PM, on 2/26/12 at 10:00 AM and 4:00 PM and on 2/27/12 at 10:00 AM.
g. "...SPIRONOLACTONE 25 MG TABS TAKE ONE BY MOUTH EVERY DAY... 10:00 AM..."
There were no initials indicating the spironolactone had been given on 2/9/12 and 3/27/12 at 10:00 AM.
h. "...SIMVASTATIN TAB 40 MG ONE TAB MONDAYS, WEDNESDAYS AND FRIDAYS... 8:00 AM..." There were no initials indicating the simvastatin had been given on 3/2/12 at 8:00 AM.
i. "...DIOVAN TAB 80 MG ONE TAB BY MOUTH EVERY DAY—HOLD IF SBP LESS THAN 110..."
There were no initials indicating the blood pressure had been recorded on 1/5/12, 2/1/12, 2/3/12, 2/26/12 and 2/27/12 and no initials indicating the diovan had been given on 2/27/12.
j. "...PHENYTOIN EX [extended] CAP 100 MG THREE CAPSULES BY MOUTH AT BEDTIME... 8:00 PM..." There were no initials indicating the phenytoin had been given on 1/5/12, 2/29/12, 3/24/12 and 3/26/12 at 8:00 PM.
k. "...SKIN AUDIT WEEKLY... SATURDAY 7-3..."
There were no initials indicating a weekly skin audit had been done on 1/7/12, 1/14/12, 1/21/12, 1/28/12, 2/4/12, 2/11/12 and 2/18/12. There were no indications in the record as to why the medications and skin audits were not documented as being done.

12. Medical record review for Random Resident (RR) #4 documented an admission date of 8/15/11 with a diagnoses of Hypertension, Cerebral Vascular Accident, Left Sided Hemiplegia, Debility and Vitamin D Deficiency. Review of physician's telephone orders dated 2/3/12 documented to increase Norvasc
<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction</th>
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</thead>
<tbody>
<tr>
<td>F 514</td>
<td>Continued From page 32</td>
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<tr>
<td></td>
<td>(Amlodipine) to 5 mg by mouth every day. Review of physician orders dated 2/21/12 documented &quot;AMLODIPINE 2.5 mg TABLET ONE TAB BY MOUTH EVERY DAY...&quot;</td>
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<td>Observation in RR #4's room on 4/3/12 at 8:30 AM, Nurse #6 administered Amlodipine 5 mg by mouth to RR #4.</td>
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<td>During an interview at the 300/400 nurses' station on 4/3/12 at 9:13 AM, Nurse #6 confirmed the order on 2/3/12 to increase the Norvasc to 5 mg po every day was not brought forward on the most current physician's order. Nurse #6 stated, &quot;Here it [Norvasc] was increased but they [nurses] didn't bring it over.&quot;</td>
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