F 241 483.15(a) DIGNITY
SS=D
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 policy review and observations, it was determined that nurse #1 failed to respect residents by failing to knock or gain permission to enter residents’ rooms during the medication administration pass.

The findings included:
Review of the facility’s medication administration policy documented "...Knock on the patient’s door before entering..."

Observations on the South hallway on 9/28/09 starting at 4:25 PM Nurse #1 entered Random Resident (RR) #2’s room twice, without knocking or gaining permission to enter RR #2’s room.

Observations on the South hallway on 9/28/09 at 4:40 PM Nurse #1 entered resident rooms 115 and 116 to do fingerstick blood sugars. Nurse #1 entered room 115 four times without knocking or gaining permission to enter room 115. Nurse #1 did not knock or gain permission to enter resident room 116.

F 278 483.20(g) (i) RESIDENT ASSESSMENT
SS=D
The assessment must accurately reflect the resident’s status.

A registered nurse must conduct or coordinate

This plan of correction is submitted as required under State and Federal law.
The submission of the plan does not constitute an admission on the part of NHC Milan as to the accuracy of the surveyors findings nor the conclusions drawn there from. The centers submission of the plan of correction does not constitute an admission on the part of the center that the findings cited are accurate, that the finding constitute a deficiency or the scope and severity regarding the deficiencies cited are correctly applied.

The facility will continue to promote care for the residents in a manner & in an environment that maintains & enhances each resident's dignity & respect in full recognition of his or her individuality.
Nurse #1 was counseled 10-7-09, 10-7-09 on respecting resident’s by knocking & gaining permission to enter residents room during medication administration pass by DON.
All licensed nurses were reinserviced 10-13-09 on respecting residents 10-13-09 by knocking & gaining permission to enter residents room during medication administration pass by DON.
Continued on 1B
DON, ADON, and/or unit manager will begin QA process week of 10-13-09 & will observe licensed nurses randomly during medication administration pass to ensure nurse is knocking & gaining permission to enter the resident's room prior to entrance. QA process will continue weekly x4, then report to QA committee. If standards are not met, follow-up will be completed until all criteria is acceptable.

The assessment will continue to accurately reflect the resident's status. A registered nurse will conduct and coordinate each assessment with the appropriate participation of health professions.
F 278 Continued From page 1

each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to ensure a Registered Nurse (RN) signed and dated the Minimum Data Set (MDS) for 1 of 23 (Resident #7) sampled residents and 1 of 11 Random Residents (RR #8).

The findings included:

1. Medical record review for Resident #7 documented an admission date of 1/24/06 with current diagnoses of Hypertension, Dementia,
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<thead>
<tr>
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<tbody>
<tr>
<td>445069</td>
<td>A. BUILDING</td>
<td>09/29/2009</td>
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<td>B. WING</td>
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**NHC HEALTHCARE, MILAN**

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

8017 DOGWOOD LANE PO BOX A

MILAN, TN 38358

<table>
<thead>
<tr>
<th>(X4) ID PREFIX</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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| F 278          | Continued From page 2
|                | Degenerative Joint Disease and Mild Anxiety. Review of the full assessment MDS form with an assessment reference date of 11/26/08 had no signature or date of the RN coordinating the assessment. |
|                | 2. Medical record review for RR #8 documented an admission date of 9/10/09 with diagnoses of Left Intracerebral Hemorrhage, Right Sided Hemiplegia, Dysarthria, Dysphagia, Facial Droop, Hypertension, Gastritis, Duodenitis, Asthma, Tobacco Abuse, Alcohol Abuse, Gastrostomy and Urinary Retention. Review of the full MDS assessment form with an assessment reference date of 9/21/09 had no signature or date of the RN coordinating the assessment. |
|                | During an interview in the MDS Coordinator's office on 9/29/09 at 10:40 AM, the MDS Coordinator stated, "It [MDS] has to be signed if it is on the chart." |

**F 280 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS**

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.

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 RN 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.

Care plan for resident #17 was 9-29-09 revised to reflect residents...
F 280 Continued From page 3
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 for emergency bleeding for 1 of 23 (Resident #17) sampled residents.

The findings included:
Medical record review for Resident #17 documented an admission date of 9/18/09 with diagnoses of Chronic Kidney Failure, Dialysis, Congestive Heart Failure, Diabetes Mellitus, Hypertension and Amputations of the left great toe, and the 2nd, 3rd and 4th toes of the right foot. Review of Resident #17’s care plan dated 9/18/09 revealed the facility failed to document a care plan for emergency bleeding.

During an interview in the North Hall Nurses’ Station on 9/29/09 at 8:35 AM, the Director of Nursing (DON) was asked if there was a care plan for emergency bleeding. The DON stated, “No.”

F 309 483.25 QUALITY OF CARE

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

F 309 Each resident will continue to receive and the facility will continue to provide the necessary care and services to attain and 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, observation and interview, it was determined the facility failed to provide necessary care and services according to physician’s orders for sliding scale insulin or a treatment for 5 of 21 (Residents #3, 5, 8, 18 and 20) sampled residents.

The finding included:

### F 309

Continued From page 5

PRN [as needed]...

Observations in Resident #5's room on 9/28/09 at 10:50 AM revealed Nurse #7 performed a dressing change on Resident #5's left hip. After cleaning Resident #5's wound, Nurse #7 applied Safe-Gel without a physician's order.

During an interview at the North Nurses station on 9/29/09 at 1:50 PM, Nurse #7 stated, "I may have forgotten to write it [order for Safe-Gel]...I don't see it [order for Safe-Gel]."

3. Medical record review for Resident #8 documented an admission date of 2/10/09 with diagnoses of Diabetes, Peripheral Neuropathy, Osteopenia, Depression and Hyperlipidemia. Review of the physician's orders dated 7/14/09 and 9/14/09 documented, "...ACCUCHECKS: BEFORE MEALS, AT BEDTIME & AT 2 AM... HUMALOG SS INS [insulin]: SNACK & RE-CHECK, 61-200 = 0 UNITS, 201-300 = 4 UNITS, 301-400 = 8 UNITS, >401 = 12 UNITS..."

Review of Resident #8's July 2009 diabetic monitoring log revealed the following:

- a. 7/1/09 at 2 AM - accuechek was 55, there was no documentation of a snack given or that the accuechek was rechecked.
- b. 7/2/09 at 2 AM - accuechek was 42, there was no documentation the accuechek was rechecked.
- c. 7/5/09 at 11:30 AM - accuechek was 54, there was no documentation of a snack given.
- d. 7/9/09 at 11:30 AM - accuechek was 49, there was no documentation of a snack given.
- e. 7/11/09 at 11:30 AM - accuechek was 55, there was no documentation of a snack given.
- f. 7/12/09 at 2 AM - accuechek was 40, there was no documentation the accuechek was rechecked.

**QA process will continue weekly x4, then report to QA committe. If standards are not met, follow-up will be completed until all criteria is acceptable.**
F 309 Continued From page 6

g. 7/13/09 at 2 AM - accucheck was 55, there was no documentation the accucheck was rechecked.
h. 7/14/09 at 2 AM - accucheck was 58, there was no documentation the accucheck was rechecked.
i. 7/16/09 at 11:30 AM - accucheck was 43, there was no documentation of a snack given.
j. 7/17/09 at 11:30 AM - accucheck was 64, there was no documentation of a snack given or that the accucheck was rechecked.
k. 7/20/09 at 2 AM - accucheck was 60, there was no documentation the accucheck was rechecked.
l. 7/21/09 at 4:40 PM - accucheck was 58, there was no documentation the accucheck was rechecked.
m. 7/22/09 at 11:30 AM - accucheck was 43, there was no documentation the accucheck was rechecked.
n. 7/24/09 at 4:30 PM - accucheck was 64, there was no documentation of a snack given or that the accucheck was rechecked.
o. 7/30/09 at 2 AM - accucheck was 48, there was no documentation the accucheck was rechecked.

Review of Resident #8's August 2009 diabetic monitoring log revealed the following:
a. 8/4/09 at 4:30 PM - accucheck was 45, there was no documentation of a snack given or that the accucheck was rechecked.
b. 8/5/09 at 4:30 PM - accucheck was 49, there was no documentation of a snack given or that the accucheck was rechecked.
c. 8/6/09 at 11:30 AM - accucheck was 52, there was no documentation of a snack given or that the accucheck was rechecked.
d. 8/11/09 at 2 AM - accucheck was 60, there was no documentation the accucheck was rechecked.
e. 8/11/09 at 6:30 AM - accucheck was 61, there was no documentation of a snack given or that the accucheck was rechecked.
F 309 Continued From page 7

f. 8/12/09 at 11:30 AM - accuchek was 64, there was no documentation of a snack given or that the accuchek was rechecked.
g. 8/13/09 at 11:30 AM - accuchek was 32, there was no documentation of a snack given.
h. 8/14/09 at 11:30 AM - accuchek was 60, there was no documentation of a snack given or that the accuchek was rechecked.
i. 8/14/09 at 4:30 AM - accuchek was 60, there was no documentation of a snack given or that the accuchek was rechecked.
j. 8/15/09 at 11:00 PM - accuchek was 62, there was no documentation of a snack given or that the accuchek was rechecked.
k. 8/16/09 at 11:30 AM - accuchek was 53, there was no documentation of a snack given or that the accuchek was rechecked.
l. 8/20/09 at 2 AM - accuchek was 49, there was no documentation that the accuchek was rechecked.
m. 8/22/09 at 11:30 AM - accuchek was 51, there was no documentation of a snack given or that the accuchek was rechecked.
n. 8/28/09 at 4:30 PM - accuchek was 53, there was no documentation of a snack given.
o. 8/31/09 at 11:30 AM - accuchek was 59, there was no documentation of a snack given or that the accuchek was rechecked.

Review of Resident #8's September 2009 diabetic monitoring log revealed the following:
a. 9/1/09 at 11:00 PM - accuchek was 57, there was no documentation of a snack given.
b. 9/13/09 at 11:30 AM - accuchek was 33, there was no documentation of a snack given.
c. 9/14/09 at 2 AM - accuchek was 60, there was no documentation of a snack given or that the accuchek was rechecked.
d. 9/16/09 at 4:30 PM - accuchek was 63, there
F 309. Continued From page 8
was no documentation of a snack given or that
the accucheck was rechecked.
e. 9/17/09 at 11:30 AM - accucheck was 51, there
was no documentation of a snack given or that
the accucheck was rechecked.
f. 9/25/09 at 11:30 AM - accucheck was 50, there
was no documentation of a snack given or that
the accucheck was rechecked.

During an interview in the conference room on
9/29/09 at 8:50 AM, the Director of Nursing
(DON) stated, "We notify the MD [Medical Doctor]
every week of BS on diabetic patients. We
recheck it [accucheck] if it is low and notify MD, if
lower than 60. We recheck [accucheck] it a lot.
Rechecking depends on the residents status. If
she is alert, can give a snack/ juice and then
recheck. If not alert, we can get a order for
glucagon or get an IV [intravenous] started."

4. Medical record review for Resident #18
documented an admission date of 9/9/09
Diabetes Mellitus, Compression Fracture
Thoracic 12 and Lumbar 1, Diabetes Mellitus,
Osteopenia, Osteoporosis and Syncope. Review
of a physician's order dated 9/9/09 documented,
"Accucheck AC [before meals] and HS [hour of
sleep] w/ Novolog SSI: 151-200 = 3 units,
201-250 = 5 units, 251-300 = 8 units, 301-350 = 10
units, 351-400 = 12 units, >400 = 15 units Call MD."

Review of Resident #18's September 2009
diabetic sliding scale monitoring log revealed the
following:
a. 9/13/09 at 4:30 PM - accucheck was 52,
hypoglycemic/snack, no documentation of BS
being rechecked.
b. 9/14/09 at 9:00 PM - accucheck was 401, no
documentation that MD was notified of the
**F 309** Continued From page 9

- Elevated BS.
  - c. 9/16/09 at 9:00 PM - Accucheck was 50, snack, no documentation of BS being rechecked.
  - d. 9/19/09 at 11:30 AM - Accucheck was 60, banana, no documentation of BS being rechecked.
  - e. 9/23/09 at 9:00 PM - Accucheck was 60, juice/snack, no documentation of BS being rechecked.
  - f. 9/25/09 at 11:30 AM - Accucheck was 52, no documentation of BS being rechecked.
  - g. 9/25/09 at 9:00 PM - Accucheck was 52, snack/juice, no documentation of BS being rechecked.

The facility was unable to provide documentation that Resident #18’s low blood sugars were rechecked or that the MD was notified of the elevated blood sugars.

- 5. Medical record review for Resident #20 documented an admission date of 10/9/08 with diagnoses of Right Above Knee Amputation, Diabetes Mellitus, Peripheral Vascular Disease and Left Heel and Toes Pressure Ulcer and Legally Blind. Review of a physician’s order dated 6/26/09 documented, “Accuchecks BID [two times a day] @ [at] 0600 [6:00 AM] and 2100 [9:00 PM] x [times] 2 weeks then return to previous orders: Novolin R: 60-70=apple juice, 80-150=0 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, >400=12 units and call MD.”

Review of Resident #20’s July 2009 diabetic monitoring log for 7/5/09 at 9:00 PM documented a BS of 210 and 4 units of insulin was given. There was no physician’s order for insulin to be given.

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**F 312** 483.25(a)(3) ACTIVITIES OF DAILY LIVING

**SS=D**
F 312 Continued From page 10

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:
Based on observations and an interview, it was determined the facility failed to ensure staff provided personal care for a resident who was unable to carry out activities of daily living (ADL) by not combing the hair of 1 of 8 Random Residents (RR #6) observed.

The findings included:

Observations on the 100 hall on 9/27/09 at 10:00 AM and on 9/28/09 at 4:20 PM, revealed RR #6's hair was uncombed.

Observations in the main dining room on 9/28/09 at 10:45 AM and on 9/29/09 at 1:55 PM, revealed RR #6's hair was uncombed.

Observations in the hallway by the Director of Nurses office on 9/29/09 at 9:40 AM, revealed RR #6's hair was uncombed.

During an interview on the 300 hall on 9/28/09 at 2:00 PM, when asked how often RR #6's hair was combed, Nurse #8 stated, "Certified Nurses Assistants take it down once a month and one of us will braid it..."

F 315 483.25(d) URINARY INCONTINENCE

Based on the resident's comprehensive assessment, the facility must ensure that a
### F 315

Continued From page 11

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

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

Based on policy review, medical record review, observations and interview, it was determined the facility staff failed pericare during 1 of 1 (Resident #4) observations of pericare, failed to follow physician's order to insert a Foley for 1 of 12 (Resident #13) residents with a Foley catheter, failed to update the recertification orders for discontinuing a Foley catheter for 2 of 23 (Residents #1 and 11) sampled residents, and failed to keep Foley catheter tubing off of the floor for 1 of 4 (Resident #18) sampled residents and 3 of 8 Random Residents (RR #5, 7 and 8) RR with indwelling Foley catheters.

The findings include:

F 315 Continued From page 12

Observations in Resident #1’s room on 9/27/09 at 10:30 AM, on 9/28/09 at 7:15 AM and on 9/29/09 at 7:28 AM, revealed Resident #1 did not have an indwelling Foley catheter.

2. Review of facility “INCONTINENT CARE” policy documented, "...10. Wash peri-area front to back, pat dry,...”

Observations in Resident #4’s room on 9/27/09 at 12:15 PM, revealed Certified Nursing Assistant (CNA) #3 provided peri-care for Resident #4. After positioning Resident #4, CNA #3 washed over the left side of the labia, over the right side of the labia and over the middle of the labia. When CNA #3 cleaned the anal area of Resident #4, CNA #3 washed over the top of the right buttocks from the area near the coccyx towards the anus, over the top of the left buttocks from the area near the coccyx towards the anus, and over the top of the crease of the buttocks from the area near the coccyx towards the anus. When CNA #3 dried Resident #4, she slid the towel from the coccyx area down over the right buttocks towards the anal area and repeated that action over the left buttocks.

During an interview at the South Hall nurses’ station on 9/29/09 at 7:45 AM, the surveyor informed CNA #3 of her observations made during Resident #4’s peri-care. CNA #3 stated, “I was just nervous…”

3. Medical record review for Resident #11 documented a readmission date of 12/15/06 with diagnoses of Advanced Dementia, Chronic Renal Failure, Cardiovascular Disease, Gastrostomy, Hypertension. Review of the physician's recertification orders dated 8/14/09 documented...
F 315 Continued From page 13

...16/5ML Foley CATH [catheter] TO BSD [bedside], F/C [ Foley catheter] Care EV [every]
SHIFT, CHGE [change] EVERY MONTH & PRN [as needed]..."

Observations in Resident #11’s room on 9/27/09 at 10:45 AM and on 9/28/09 at 7:25 AM and 2:30 PM, revealed Resident #11 did not have an indwelling Foley catheter.

During an interview in the North Nurses’ Station on 9/28/09 at 2:45 PM, Nurse #11 stated, "...let me look at the chart [Resident #11’s] ...there is not one [order to discontinue Foley] ..."


Observation in Resident #13’s room on 9/27/09 at 9:00 AM, revealed Resident #13 did not have an indwelling Foley catheter.

During an interview on South Nurses’ Station on 9/28/09 at 4:00 PM, Nurse #4 stated, "No, she [Resident #13] has never had a Foley, that order may be just in case she needs it..."

5. Review of the facility’s "CATHETER DRAINAGE SYSTEM, CLOSED" policy documented, "...Never allow drainage bag to touch floor ..."
F 315 Continued From page 14


Observations in Resident's #18's room on 9/28/09 at 3:55 PM, revealed Resident #18 seated in a wheelchair, with her catheter tubing touching the floor.

b. Medical record review for RR #5 documented an admission date of 10/26/06 with diagnoses of Primary Seizures, Peripheral Neuropathy, status post Head Injury, Osteoarthritis and Hypertension. Review of a physician's order dated 6/26/09 documented, "#16 F/C c 5cc bulb to BSDB [bedside drainage bag] -Routine F/C Care q shift & PRN."

Observations in RR #5's room on 9/27/09 at 8:40 AM, 10:30 AM and 1:00 PM, revealed RR #5 seated in a wheelchair with the spigot of his catheter tubing touching the floor.

c. Medical record review for RR #7 documented an admission date of 8/27/09 with diagnoses of Cerebral Vascular Accident, Gastronomy, Dementia, Atrial Fibrillation, Hypertension and Diabetes Mellitus. Review of a physician's order dated 9/15/09 documented, "#16/10 FC to BSD d/t Urinary Retention R/T BPH [benign prostate hypertrophy] and H/O [history of] Prostrate Ca
F 315  Continued From page 15
[Cancer] and Acute Renal Failure."

Observations in the Physical Therapy room on
9/29/09 at 10:45 AM, revealed RR #7 seated in a
wheelchair, with his catheter tubing touching the
floor.

During an interview at the North nurses’ station on
9/29/09 at 2:30 PM, Nurse #9 stated, "I would
expect the catheter bag to be in a privacy bag.
The catheter bag or tubing should never be in the
floor."

d. Medical record review for RR #8 documented
an admission date of 9/10/09 with the diagnoses
of Left Intracerebral Hemorrhage, Right Sided
Hemiplegia, Dysarthria, Dysphagia, Facial Droop
Hypertension, Gastroitis, Duodenitis, Asthma,
Tobacco Abuse, Alcohol Abuse, Gastrostomy and
Urinary Retention.

Observations on the 400 hall on 9/29/09 at 10:35
AM, revealed RR #8 in wheelchair being assisted
to the Physical Therapy Department. RR #8’s
Foley Catheter tubing and bag were dragging the
floor.

F 332  483.25(4) MEDICATION ERRORS

SS=E

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

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review,
observations and interviews, it was determined
the facility failed to ensure 3 of 7 (Nurses #2, 3
and 5) nurses administered medications with a

F 332  The facility will continue to
ensure that it is free of medication
error rates of five percent or
greater.
Nurse #1 was counseled by DON 10-2-09
10-2-09 on administration of
medications ordered to be given
with food.
Nurse #3 was counseled by DON 9-29-09
9-29-09 on administration of
medications ordered to be given
with meals.
Nurse #5 was counseled by DON 9-29-09
F 332 Continued From page 16
medication error rate of less than 5 percent (%). A total of 6 medication errors were observed out of 41 opportunities for errors, resulting in a medication error rate of 14.63%.

The findings included:

1. Review of the facility's medication administration policy documented, "PURPOSE: To give medications per physician's orders... PROCEDURE: 1. Read the label 3 times before administering the medication: First time when comparing the label with medication sheet; second when pouring medication; and third when pour is completed..."


Observations in RR #1's room on 9/27/09 at 4:25 PM, revealed Nurse #1 administered Ferrous Sulfate 325 mg to RR #1. The failure to administer the Ferrous Sulfate with food resulted in medication error #1.

3. Medical record review for RR #2 documented an admission date of 10/5/07 with diagnoses of Osteoporosis, Severe Iron Deficiency Anemia, Severe Hypothyroidism and Senile Dementia. Review of a physician's order dated 8/17/09 documented, "FERROUS SULFATE 325MG ONE (1) PO BID WITH FOOD."
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

445069

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING

B. WING

**(X3) DATE SURVEY COMPLETED:**

09/29/2009

---

**NAME OF PROVIDER OR SUPPLIER:**

NHC HEALTHCARE, MILAN

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

8017 DOGWOOD LANE PO BOX A

MILAN, TN 38358

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**F 332** Continued From page 17

Observations in RR #2's room on 9/27/09 at 4:30 PM, revealed Nurse #1 administered Ferrous Sulfate 325 mg to RR #2. The failure to administer the Ferrous Sulfate with food resulted in medication error #2.

4. Medical record review for RR #3 documented an admission date of 7/3/08 with diagnoses of Diabetes Mellitus, Parkinson's Disease, Congestive Heart Failure, Vision Impairment and History of Cerebral Vascular Accident. Review of a physician's order dated 9/19/09 documented, "JANUVIA 100 MG TABLET ONE (1) PO DAILY W/ [with] BREAKFAST, METFORMIN HCL [hydrochloride] ONE (1) PO BID W/BREAKFAST & [and] SUPPER."

Observations in RR #3's room on 9/28/09 at 7:25 AM, revealed Nurse #3 administered Januvia 100 mg and Metformin 1000 mg to RR #3. The failure to administer Januvia and Metformin with breakfast resulted in medication errors #3 and #4.

During an interview on the South hall on 9/28/09 at 2:10 PM, Nurse #3 stated, "I should have waited until she [RR #3] had her breakfast."

5. Medical record review for RR #4 documented an admission date of 11/3/08 with diagnoses of Primary Mental Illness, Chronic Anxiety, Depression, Hypertension and Stress Incontinence. Review of a physician's order dated 9/21/09 documented, "PATANOL 0.1% EYE DROPS TWO (2) DROPS BID TO BOTH EYES, FLOVENT 220 MCG [micrograms] ONE (1) PUFF BID VIA INHALER."

Observations in RR #4's room on 9/28/09 at 9:25 AM, revealed Nurse #5 administered Flovent
F 332 Continued From page 18

Inhaler: 2 puffs and one drop of Patanol in each of RR #4's eyes. The administration of 2 puffs of the Flovent inhaler resulted in medication error #5. The failure to administer 2 drops of the Patanol in both of RR #4's eyes resulted in medication error #6.

During an interview on the South hall on 9/28/09 at 2:28 PM, Nurse #5 stated, "I had it [referring to the eye drops and inhaler] all mixed up."

F 341 483.60(b), (d), (e) PHARMACY SERVICES

SS=E

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, and determines that drug records are in order and that an account of all controlled drugs are maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to
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abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

Based on policy review, observation and interview, it was determined the facility failed to ensure medications were dated when opened and medications were not stored past their expiration date in 3 of 7 (North Medication Room, South Medication Room and Family 2 Medication Cart on South Hall) medication storage areas.

The findings included:

1. Review of the facility's medication storage policy documented, "...Drugs shall not be kept on hand after the expiration date on the label..."

Review of the facility's preparation and general guidelines policy documented, "...VIALS AND AMPULES OF INJECTABLE MEDICATIONS...date opened and the initials...Medication in multidose vials...used...twenty-eight (28) days...date first use..."

2. Observations in the North Medication Room on 9/29/09 at 10:15 AM, revealed a vial of Influenza Vaccine with no opened date.

During an interview in the North Medication Room on 9/29/09 at 10:15 AM, Nurse #8 stated, "...I placed it [the open undated vial Influenza Vaccine] in sharp box."
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3. Observations in the South Medication Room on 9/29/09 at 10:25 AM, revealed 26 syringes of Heparin lock stored past the expiration date of 8/09 and 5 boxes of Fleets enema stored past the expiration date of 7/09.

During an interview in the South Medication Room on 9/29/09 at 10:25 AM, the Director of Nurses stated, "...checked [the medications in situ] every Monday...

4. Observations in the Family 2 Medication Cart on the South Hall on 9/29/09 at 11:15 AM, revealed Xalatan .005% (eye drops) with an expiration date of 9/24/09 and an opened vial of Novolin 70/30 Insulin with date when opened. The Director of Nurses was present during these observations.

F 441 483.65(a) INFECTION CONTROL

The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility, decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.

This REQUIREMENT is not met as evidenced by:
Based on policy review, observations and interviews, it was determined facility staff failed to follow infection control practices to prevent the spread of infections during medication.

F 441 The facility will continue to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and prevent the development and transmission of disease and infection. The facility will establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. Nurse #3 was counseled by DON 9-28-09 9-28-09 on proper cleaning of glucometer after each use.
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administration completed by 1 of 6 (Nurse #3) nurses, during 2 of 2 dressing changes completed by Nurse #7 and during 1 of 1 pericare completed by Certified Nursing Assistant (CNA #3) for Resident #4.

The findings included:

1. Review of the facility's "GLUCOMETER CLEANING" policy documented, "PURPOSE: To decrease the number of microorganisms, preventing cross contamination between staff and patients...PROCEDURE: 1. Apply gloves 2. Clean outside of glucometer with alcohol prep pad 3. Remove gloves 4. Wash hands."

Observations on the South hallway on 9/28/09 at 7:20 AM, revealed Nurse #3 removed the glucometer and a bottle of accuchek strips from the medication cart and placed it on Random Resident (RR) #10's overbed table. After using the glucometer, Nurse #3 placed the glucometer and bottle of accuchek strips in her uniform pocket. Nurse #3 did not cleanse the glucometer prior to or after using it.

Observations on the South hallway on 9/28/09 at 7:25 AM, revealed Nurse #3 removed the glucometer and bottle of accuchek strips from her uniform pocket and placed them on RR #3's overbed table. After using the glucometer Nurse #3 placed the glucometer and bottle of accuchek strips on top of the medication cart. Nurse #3 did not cleanse the glucometer after using it.

Observations on the South hallway on 9/28/09 at 7:40 AM, revealed Nurse #3 removed the glucometer and bottle of accuchek strips from the top of the medication cart and placed them on
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RR #11’s overbed table. After using the glucometer, Nurse #3 returned the glucometer and bottle of accuchek strips to the medication cart. Nurse #3 did not cleanse the glucometer after using it.

During an interview on the South hallway on 9/28/09 at 2:15 PM, Nurse #3 stated, “I should have cleaned it [referring to the glucometer] between the residents.”

During an interview in the conference room on 9/28/09 at 2:45 PM, the Director of Nursing stated, “It [referring to the glucometer] should be cleaned between patients.”

2. Review of the facility’s “DRESSING: WOUND CHANGES” policy documented, "PROCEDURES... 16. cleanse wound from center out...

a. Medical record review for Resident #5 documented an admission date of 6/6/09 with a readmission date of 8/12/09 with diagnosis of Seizures, Deep Vein Thrombosis, Tracheostomy, Gastrostomy and Pressure Sores.

Observations in Resident #5’s room on 9/28/09 at 9:50 AM, revealed Nurse #7 performed a dressing change on Resident #5. After Nurse #7 washed her hands, the overbed table (OBT) was moved to the left side of Resident #5’s bed. Nurse #7 placed a glove on her right hand. A empty gauze package fell on the floor. With her ungloved left hand Nurse #7 picked the package from the floor and placed it back on the clean barrier on the OBT. Next a pen and marker fell from the OBT to the floor and Nurse #7 picked the pen and marker up with her left hand. Nurse
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#7 proceeded to put a glove on her left and removed the dressing from Resident #5’s left hip.

b. Observations of a dressing change in Resident #10’s room on 9/28/09 at 2:20 PM, Nurse #7 gathered supplies and removed the old dressing from Resident #10’s left leg and heel. Resident #10 initially held his foot up, but then let it drift down until the exposed wound on the left heel touched the incontinence pad on the bed, which had a light, yellow ring under the heel area. After washing her hands and donning new gloves, Nurse #7 cleansed the wound on the left heel with a 4 by (x) 4 soaked with saline solution. Nurse #7 started at the bottom of the heel and moved the 4x4 up the wound towards the toes, around the upper edges of the wound and then back down around the outer edge of the wound towards the heel area. After disposing of the used 4x4, after washing her hands Nurse #7 donned new gloves. Nurse #7 then took a dry 4x4 and blotted the wound dry, moving all over the wound area, moving up, down, and side to side.

After washing her hands and donning new gloves, Nurse #7 removed the dressing from Resident #10’s right leg and heel. Resident #10’s right heel with the exposed wound rested on the incontinence pad which had a light yellow ring under the heel area. After washing her hands and donning new gloves, Nurse #7 cleansed the wound on Resident #10’s right heel with a 4x4 soaked with saline solution. Nurse #7 started at the top of the wound, moved to bottom of the heel and made a semicircular motion at the bottom. Nurse #7 lifted the 4x4 off of the heel, took it to the top of the wound and made another sweep down the wound area towards the bottom of the heel, ending up with another semicircular motion.
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    at the bottom of the wound. After disposing of the  
    4x4, washing her hands and donning new gloves,  
    Nurse #7 took a dry 4x4 and blotted the wound  
    dry, moving all over the wound area, moving up,  
    down, and side to side.  

    During an interview at the treatment cart at the  
    end of the 200 Hall on 9/29/09 at 10:10 AM,  
    Nurse #7 was given data about the observations  
    of the dressing change to Resident #10. Nurse #7  
    nodded her head yes and stated, "Thank you [for  
    the information]."

    3. Review of the facility's "INCONTINENT CARE"  
       policy documented,"...10. Wash peri-area front to  
       back, pat dry..."

    Observations in Resident #4's room on 9/28/09 at  
    12:15 PM, revealed Certified Nursing Assistant  
    (CNA #3) provided peri-care to Resident #4. CNA  
    #3 put on gloves and turned the faucet on and off  
    to get water into the wash basin. After providing  
    the peri-care to the front of Resident #4's  
    perineum, CNA #3, wearing the same gloves with  
    which she provided the care, went to Resident  
    #4's chest of drawers, opened up a drawer, and  
    pulled out a clean towel and some other clean  
    washcloths. CNA #3 positionned Resident #4 and  
    cleansed Resident #4's rectal area. CNA #3  
    continued to wear the same gloves. CNA #3  
    provided care to Resident #4's rectal area, put  
    new brief pads on, pulled up Resident #4's pants  
    and went to the bathroom with the wash basin  
    used for the perineal care, and proceeded to turn  
    the water faucet off and on as she rinsed the  
    wash basin. CNA #3 took a towel and dried the  
    wash basin and put it back into a drawer. CNA #3  
    then put the dirty linen into a plastic bag and then  
    took off the gloves that she had been wearing.
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since the beginning of the procedure.

During an interview at the South Hall nurses' station on 9/29/09 at 7:45 AM, the surveyor informed CNA #3 of her observations during the peri-care for resident #4. CNA #3 stated, "I was just nervous..."

F 444 483.65(b)(3) PREVENTING SPREAD OF INFECTION

The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

This REQUIREMENT is not met as evidenced by:

Based on policy review and observations, it was determined the facility staff failed to use acceptable professional practices during handwashing when 1 of 6 (Nurse #1) nurses observed administering medications re-contaminated her hands by turning the water off before drying her hands.

The findings included:

Review of the facility’s handwashing policy documented, "...Dry hands with a paper towel. Turn water off with paper towel used to dry hands..."

Observations during the medication administration pass on 9/27/09 revealed the following:

a. In Room 112 at 4:25 PM - Nurse #1 washed her hands, turned off the water and then dried her hands. Nurse #1 repeated this twice while in
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b. In Room 115 at 4:40 PM and 4:55 PM - Nurse #1 washed her hands, turned off the water and then dried her hands. Nurse #1 repeated this procedure four times while in Room 115.
c. In Room 116 at 4:45 PM, Nurse #1 washed her hands, turned off the water and then dried her hands.

Nurse #1 did not dry her hands and turn the water off with a paper towel in accordance with the facility's handwashing policy.

F 502 483.75(j)(1) LABORATORY SERVICES

SS=D

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to obtain laboratory services for 1 of 23 (Resident #15) sampled residents.

The findings included:

Medical record review for Resident #15 documented an admission date of 6/20/07 with a current diagnoses of Hypertension, Calf and Neck Pain, Morbid Obesity, Arthritis, Anemia and Diabetes. Review of Resident #15’s Physician’s orders dated June and July 2009 documented, "CBC [Complete Blood Count], CMP [Complete Metabolic Profile] EVERY MONTH...
Review of the laboratory services results revealed a CMP was done 12/08 and a CBC was done 9/22/09.

F 502. The facility will continue to provide and obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Complete medical review of resident #15 9-30-09 with revisions to comply to current physician’s orders for monthly labs. Reviews of residents with monthly lab orders on 10-9-09 by DON and/or unit manager for accuracy of obtaining labs when ordered. All licensed nurses were 10-13-09 inserviced 10-13-09 on obtaining labs as ordered by physician by DON. DON, ADON, and/or unit manager will begin QA process week of 10-19-09 and randomly check patient records for accuracy of obtaining labs as ordered by physician. QA process will continue weekly x4, then report to QA committee.
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The facility was unable to provide documentation that a CBC and CMP were done monthly as ordered.

During an interview in the conference room on 9/29/09 at 1:35 PM, the Director of Nurses (DON) stated, "Lab was left off. Our fault."

### F 502 If standards are not met, follow-up will be completed until all criteria is acceptable.