F 241 483.15(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 observations, it was determined 1 of 2 Certified Nursing Assistants (CNA #4) failed to knock on the door or gain permission prior to entering residents' rooms during 1 of 2 dining observations.

The findings included:

Observations of on the West hall on 3/29/11 at 4:45 PM, revealed CNA #4 entered resident room 28 with a supper tray without knocking or gaining permission to enter.

Observations on the West hall on 3/29/11 at 5:05 PM, revealed CNA #4 entered resident room 34 with a supper tray without knocking or gaining permission to enter.

Observations on the West hall on 3/29/11 at 5:07 PM, revealed CNA #4 entered resident room 33 with a supper tray without knocking or gaining permission to enter.

During an interview in the Director of Nursing's (DON) office on 3/30/11 at 1:45 PM, the DON confirmed that she would expect the CNAs to knock before entering a resident's room.

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

L2/19/11

Laboratory Directors or Provider/Supplier Representative's Signature

Title

EXCEPT AS NOTED, ALL DEFICIENCIES OBSERVED WERE CORRECTED PRIOR TO THE DATE OF SURVEY. THE FACILITY SHOULD MAKE REMAINING CORRECTIVE ACTIONS PROMPTLY AND IN ACCORDANCE WITH THE ATTACHEDͲ DEFICIENCY CORRECTIVE ACTION PLAN (D-CAP).
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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**NAME OF PROVIDER OR SUPPLIER**

**HUMPHREYS CO NURSING HOME**

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

670 HIGHWAY 13 SOUTH  
WAVERLY, TN 37185

**DATE SURVEY COMPLETED**

03/30/2011

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LCS IDENTIFYING INFORMATION)

**ID | PREFIX | TAG | PROVIDER'S PLAN OF CORRECTION**

(F241) continued for the next three quarters. These quarterly in-services began on April 13, will be repeated on April 19, 2011 and continue until April 2012.

4. The DON is responsible for monitoring compliance with the corrective action. The facility will monitor its performance to ensure the deficient practice will not recur by observing meal pass randomly on a monthly basis after completing the six weeks of observations. During the observation sessions, if a CNA is found non-compliant with the facility policy, the CNA will be corrected immediately.

If the deficient practice occurs more than one time then the disciplinary process will be exercised. (See attached monitoring tool).

The DON will provide monthly reports to the Administrator and report the in-service and observation outcomes to the quarterly Quality Improvement Committee for the next three quarters.

The next scheduled QI committee meeting is April 21, 2011. The Administrator will report in-service and observation outcomes to the Board of Directors quarterly for the next three quarters. The next Board meeting is scheduled for April 26, 2011.
The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observations and an interview, it was determined the facility failed to follow the care plan interventions of hand rolls, motion lamps and to float lower extremities for 1 of 15 (Resident #2) sampled residents observed.

The findings included:

Medical record review for Resident #2 documented an admission date of 9/28/06 with diagnoses of Alzheimer's Disease, Generalized Pain, Chronic Urinary Tract Infection and Anemia. Review of the care plan dated 1/19/11 documented, "...REQUIRES TOTAL CARE WITH ADLS [activities of daily living] R/T [related to] ALZHEIMER'S AND IMMOBILITY... APPROACH... HAND ROLLS ON AFTER BATH AND OFF AROUND 3PM... IMPAIRED SKIN INTEGRITY R/T BOWEL AND BLADDER INCONTINENCE... APPROACH... FLOAT LOWER EXTREMITIES WHEN IN BED... ACTIVITIES... APPROACH... MOTION LAMP IN ROOM AT ALL TIMES."

Observations in Resident #2's room on 3/29/11 at 9:50 AM and 11:45 AM, revealed Resident #2 in bed with no hand roll in her right hand, her lower extremities were not floating and there was not a motion lamp in her room as planned.

F282 SERVICES BY A QUALIFIED PERSON PER CARE PLAN
The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care.

1. To correct the deficiency, on April 8, 2011 the DON, MDS Coordinator and Patient Care Coordinator discussed Resident #2 and all the issues causing noncompliance with carrying out the Care Plan approaches for this resident. The following was identified and completed on April 8, 2011:
   * Evaluated the Care Plan for correct approaches.
   * Reviewed Care Plan approaches with all nurses for Resident #2 i.e., hand rolls, floating motion lamp.

2. To protect other residents, on April 8, 2011 the MDS Coordinator began reviewing all resident Care Plans for appropriateness and then checked to see that each resident's Care Plan was implemented. This was completed on April 15, 2011. On April 13 & 15, 2011 the MDS Coordinator conducted a Care Plan in-service with all the nursing staff which included the findings from the survey conducted March 28-30, 2011.

3. To ensure this deficient practice does not recur, the DON implemented an assignment process for Care Plan implementation for residents, nursing
HUMPHREYS CO NURSING HOME

F 282 Continued From page 2

During an interview in Resident #2's room on 3/29/11 at 2:30 PM, Nurse #5 stated, "No they [lower extremities] are not floating, don't know why she only has one hand roll. Will ask activity about motion lamp."

Observations in Resident #2's room on 3/30/11 at 7:30 AM and 9:55 AM, revealed Resident #2 in bed with her lower extremities were not floating as care planned.

F 332
483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE

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 review of "MED-PASS COMMON INSULINS" provided by the American Society of Consultant Pharmacist, policy reviews, medical record reviews, observations and interviews, it was determined the facility failed to ensure 2 of 5 (Nurses #1 and 4) nurses administered medications with a medication error rate of less than 5 percent (%). A total of 6 errors were observed out of 40 opportunities for error, resulting in a medication error rate of 15%.

The findings included:
1. Review of the facility's "Administration of Medication" policy documented, "...The individual administering the medication must verify the right medication, right dosage, right time and right method of administration (...review of drug label, and..."

F 282
Continued

F 282 continued supervisors will review 5 resident care plans per week for 6 weeks to ensure care plan approaches are implemented for all residents, and will report any changes to the MDS Coordinator.

4. The facility will monitor its performance to ensure the deficient practice will not recur by the DON and MDS Coordinator reviewing the assignment process on a weekly basis for compliance and effectiveness for 6 weeks. If no deficient practice is noted or the assignment process is determined to not be effective, the DON and/or MDS Coordinator will request the QI Committee to change or modify this action. The DON and MDS Coordinator will provide a quarterly outcome report to the Quality Improvement Committee for the next three quarters. The Administrator will provide a quarterly outcome report to the Board of Directors for the next three quarters. The next Board meeting is scheduled for April 26, 2011.

F 332 FREE OF MEDICATION ERROR RATES OF 5% OR MORE

The facility will ensure that it is free of medication error rates of five percent or greater.
1. To correct the deficiency, on April 10, 2011 the DON reviewed the Medication Administration Policy for
Statement of Deficiencies and Plan of Correction

K1) Provider/Supplier/CLA Identification Number: 445489

K2) Multiple Construction

A. Building

B. Wing

K3) Date Survey Completed: 03/30/2011

Name of Provider or Supplier: Humphreys Co Nursing Home

Street Address, City, State, Zip Code: 670 Highway 13 South, Waverly, TN 37185

K4) ID Prefix Tag: F 332

Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information):

F 332 Continued From page 3

physician's order...before giving the medication..."

2. Review of the facility's "Instillation of Eye Drops" policy documented, "...When administering two or more drops allow three to five minutes between each application..."

Medical record review for Random Resident (RR) #1 documented an admission date of 12/23/10 with diagnoses of Decreasing Functional Status Secondary to Left Hip Fracture, Detached Retina, Hypertension and Diabetes Mellitus. Review of a physician's order dated 3/18/11 documented, "...Pred Forte 1 gtt [drop] I, [left] eye TID [three times a day]..." Review of a physician's order dated 3/22/11 documented, "...Change Cosopt from TID to BID [two times a day], Alphagan 1 gtt (L) eye BID, Lumigan 1 gtt in [L] eye at HS [bedtime]..."

Observations in RR #1's room on 3/28/11 at 8:10 PM, Nurse #1 administered Pred Forte one gtt in RR #1's left eye. Nurse #1 waited one minute and then administered Alphagan one gtt in RR #1's left eye. Nurse #1 waited two minutes then administered Lumigan one gtt in RR #1's left eye. After waiting one minute Nurse #1 administered Cosopt one gtt in RR #1's left eye. Failure to wait at least five minutes between administration of the eye gttls resulted in four medication errors.

During an interview on the West Hall on 3/29/11 at 5:05 PM, Nurse #1 stated, "Messed up with my eye gttls, should have waited five minutes between each eye gtt."

3. Medical record review for RR #2 documented an admission date of 12/3/08 with diagnoses of

F 332 continued any needed revision. On April 11, 2011 the DON reviewed Medication Administration Policy and Procedure with each nurse who committed the deficient practice and instructed them on the correct procedure.

2. To protect other residents, the DON conducted in-services on Medication Administration & Safety on April 13 & 15, 2011 with all of the facility nurses. The medication errors committed during the survey process was discussed at the in-service training sessions.

3. To ensure this deficient practice does not recur, Nurse #1 & #4 were observed during their medication administration pass on April 8, 10, & 11, 2011 to monitor compliance with the facility Medication Administration & Safety policy and procedure. The DON, MDS Coordinator, Patient Care Coordinator, Staffing Coordinator, and OmniCare Pharmacy Consultant began weekly random Med Pass observations for a six week period beginning April 10, 2011. The DON or Patient Care Coordinator will investigate any medication errors within 96 hours for root cause and develop a corrective action plan as appropriate. All investigations and actions will be reported and discussed with the Administrator and Medical Director. This practice is a current standard at the facility.
F 332 Continued From page 4

Senile Delusions, Bipolar Disorder and Peripheral Vascular Disease. Review of a physician’s order dated 1/12/11 documented, "...THERAGRAM VITAMIN GIVE 1 TAB [tablet] BY MOUTH EVERY DAY..."

Observations in RR #2’s room on 3/29/11 at 8:35 AM, Nurse #4 administered a Multivitamin with Minerals to RR #2. The administration of the Multivitamin with Minerals resulted in a medication error.

During an interview at the nurse’s station on 3/29/11 at 2:15 PM, Nurse #4 stated, "I thought Theragran meant with minerals."

4. Review of “MED-PASS COMMON INSULINS: pharmacokinetics, compatibility, and Properties” provided by the American Society of Consultant Pharmacists for typical dosing administration of insulin related to meals documented, "...Humulin R [regular]...ONSET [in hours, unless noted] ...0.5- [to] 1... TYPICAL DOSING/COMMENTS ...30 minutes before meals..."

Medical record review for Resident #13 documented an admission date of 5/15/10 with diagnoses of Diabetes Mellitus, Hypertension, Renal Failure and Dementia. Review of a physician’s order dated 3/8/11 documented, "...NOVOLIN R...INJECT SUBCUTANEOUS PER S/S [sliding scale] FOUR TIMES A DAY...150- [to] 199= [amount of insulin to be administered] 2U [units]..."

Observations in Resident #13’s room on 3/29/11 at 3:45 PM, Nurse #1 administered 2 units of Humulin R to Resident #13. Resident #13 did not receive a meal until 4:57 PM. The administration
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<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<td>F 332</td>
<td>Continued From page 5 of the insulin more than 30 minutes before Resident #13 received his meal resulted in a medication error. During an interview in the Director of Nursing's (DON) office on 3/30/11 at 9:40 AM, the DON stated, &quot;The nurses know to give the insulin in relation to meals or to give them a substantial snack...&quot;</td>
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<td>F 514</td>
<td>483.75(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</td>
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<td>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. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to maintain accurate medical records for 1 of 17 (Resident #7) sampled residents. The findings included: Medical record review for Resident #7 documented an admission date of 6/23/89 with diagnoses of Diaphragmatic Hernia, Anxiety</td>
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HUMPHREYS CO NURSING HOME

**F 514**

**Continued from page 6**

Disorder, Hypertension, Pneumonia, Esophageal Reflux Disease, Cardiac Dysrhythmias, Depression, and Cerebral Palsy. Review of a Physician’s order dated 12/21/10 documented, “...CBC [Complete Blood Count] and BMP [Basic Metabolic Panel] every 3 months...” These orders were not transferred over to the physician’s orders dated 3/1/11. There were no supplemental orders on the chart regarding the CBC and BMP.

During an interview at the Nurses’ Station on 3/30/11 at 1:15 PM, Nurse #5 was asked about the CBC and BMP orders for Resident #7. Nurse #5 reviewed Resident #7’s chart and orders and stated, “...it was an oversight. The order [12/21/10 CBC and BMP] should have been carried over [on the 3/1/11 orders]...”

**F 514 continued**

Staffing Coordinator during the week of April 10-18, 2011 for accuracy and completeness. This will be completed on April 18, 2011.

3. To ensure this deficient practice does not recur, the DON reviewed the Facility’s Policy and Procedure for reviewing physician orders and added one nurse to the review process. This was completed on April 11, 2011.

4. During the next six weeks, the facility will monitor its performance to ensure the deficient practice will not recur by two nurses reviewing monthly certification orders for accuracy to ensure no continuation of deficient practice. The DON will evaluate the monitoring outcomes on a monthly basis and report to the Administrator monthly for one quarter and then quarterly for the next two quarters. Outcome reports will be presented to the QI Committee and evaluated over the next three quarters. The next QI Committee meeting is scheduled for April 21, 2011. The Administrator will present the outcome reports to the Board of Directors over the next three quarters. The next Board meeting is scheduled for April 26, 2011.