STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>IDENTIFICATION NUMBER: 445469</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDER/SUPPLIER/CUA</td>
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</table>

<table>
<thead>
<tr>
<th>A. BUILDING</th>
<th>B. WING</th>
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<thead>
<tr>
<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
<th>417 HIGHWAY 13 SOUTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>WAVERTY, TN 37185</td>
<td></td>
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</tbody>
</table>

05/31/2012 | (XIII) MULTIPLE CONSTRUCTION | (XIII) DATE SURVEY COMPLETED |

| NAME OF PROVIDER OR SUPPLIER | HUMPHREYS CO NURSING HOME |

<table>
<thead>
<tr>
<th>(IX) ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 164</td>
<td>483.10(e), 483.75(j)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</td>
<td>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure measures to maintain privacy during medical treatment for 2 of 13 (Residents #3 and #12) sampled residents.</td>
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<tr>
<th>ID PREFIX</th>
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<tr>
<td>TAG</td>
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<table>
<thead>
<tr>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>F 164 PERSONAL PRIVACY / Confidentiality OF RECORDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) The facility will maintain the residents right to personal privacy and confidentiality of his or her personal and clinical records.</td>
<td></td>
</tr>
<tr>
<td>2) Privacy curtain for Resident #3 was repaired by the maintenance staff on 5/31/12 that allowed curtain to be pulled around the bed. On 6/1/12 the DON in-serviced Nurse #3 on providing privacy (closing door and pulling privacy curtain) when administering nebulizer treatments to ensure privacy during medical treatment. On 6/1/12 the DON observed Nurse #3 during med pass of nebulizer treatments to two residents to ensure compliance with the standard of care for nebulizer treatments.</td>
<td></td>
</tr>
</tbody>
</table>

LABORATORY DIRECTORS OR PROVIDERS/SUPPLIER REPRESENTATIVES SIGNATURE

<table>
<thead>
<tr>
<th>TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allen A. Hult, Adm</td>
</tr>
</tbody>
</table>

DATE: [6/11/2012]

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 discloseable 50 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 discloseable 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.
The DON surveyed all other resident rooms for correct curtain tracks that would provide privacy curtains. The new tracks were ordered for eighteen rooms and will be installed upon arrival. The expected deliver date is 6/15/12. (see attached order form).

On 6/8/12 & 6/12/12, the DON, Risk Manager, & ADON in-serviced all staff (RN's, LPN's and CNAs) on resident rights for personal privacy during treatments.

The DON will conduct a facility wide in-service on Resident right and personal privacy on 6/19/12.

To ensure the deficient practice does not recur, the DON and ADON will observe med pass monthly on all licensed staff during medication administration i.e. nebulizer treatments and wound care for the next 3 months. This will begin 6/1/12.
<table>
<thead>
<tr>
<th>F 164</th>
<th>Continued From page 2</th>
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</thead>
<tbody>
<tr>
<td>During an interview in Resident #12's room on 5/31/12 at 9:30 AM, Resident #12 was asked if she wanted privacy while receiving the nebulizer treatment. Resident #12 stated, &quot;...I would like to have privacy.&quot;</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>F 280</th>
<th>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</th>
</tr>
</thead>
<tbody>
<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. 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.</td>
<td></td>
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</tbody>
</table>

| F 164 | 5. The DON will provide Med Pass observation outcomes and completion of installation of privacy tracks to the next quarterly QI Committee meeting. The next scheduled QI meeting is 7/31/12. The Administrator will report outcomes to the quarterly Board of Directors meeting. The next Scheduled Board meeting is July 24, 2012. |

<table>
<thead>
<tr>
<th>F 280</th>
<th>6/8/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>The facility will promote the resident right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment.</td>
<td></td>
</tr>
</tbody>
</table>

| F 280 | 2) On 6/1/12 the DON and MDS Coordinator reviewed care plans for Resident #6 and #10 and revised and updated care plan according to individual needs. On May 31, 2012, care plan for Resident #6 and #10 |

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review and interview, it was determined the facility failed to revise the care plan to reflect new interventions after each fall and a change in resident status of hospice for 2 of 15 (Residents #6 and #10)
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(x1) PROVIDER/SUPPLIER/ClinIC IDENTIFICATION NUMBER: 445468

(x2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(x3) DATE SURVEY COMPLETED
05/31/2012

NAME OF PROVIDER OR SUPPLIER
HUMPHREYS CO NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
679 HIGHWAY 13 SOUTH
WAVERLY, TN 37185

(x4) ID PREFIX TAG
F 280

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG
F 280

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

Completion Date

F 280

Continued From page 3
sampled residents

The findings included:

1. Review of facility’s care plan policy
documented, “...Changes in the resident's
condition must be reported to the MDS [Minimum
Data Set] Assessment Coordinator so that a
review of the resident's assessment and care
plan can be made. Documentation must be
consistent with the resident's care plan...”

2. Medical record review for Resident #6
documented an admission date of 2/3/12 with
diagnoses of Hypertension, Congestive Heart
Failure, Hypothyroidism, Chronic Obstructive
Pulmonary Disease, Psychosis and Cerebral
Vascular Accident. Review of the care plan dated
2/3/12 documented a problem of "Resident is at
risk for falls." Review of the nurses notes dated
2/9/12 at 10:15 PM documented, "...Resident was
crawling across the floor to the BR [bathroom].
When asked what she was doing she said [stated]
'I crawled OOB [out of bed] + [and] was going to
BR'...When asked why her bed alarm wasn't
going off she, 'My company [visitors] turned it off
earlier..." Review of the facility's fall intervention
documented an intervention of education in the
communication book for staff to check alarms
after visitors leave. The care plan was not revised
to reflect this new intervention after this fall.

3. Medical record review for Resident #10
documented an admission date of 5/2/11 and a
readmission date of 12/19/11 with diagnoses of
Congestive Heart Failure (CHF), Alzheimer's
Disease, Thrombosis, Pelvic Fracture, Cellulitis
and Blindness. Review of a physician's order

was revised to incorporate
Hospice care plan and fall
intervention.

On 6/4/12 the MDS
Coordinator and MDS
Coordinator in Training
reviewed all other residents
Care Plans for accuracy and
timeliness. This was
completed on 6/8/12.

4) Beginning 6/1/12, the MDS
Coordinator will participate in
weekly Resident Fall meetings
and will receive a copy of daily
MD orders to assist in
providing her with current
information to revise care plans
that reflect current
interventions for the
residents. The DON and Risk
Manager will review at least 4
care plans for accuracy on a
weekly basis for 3 months
beginning 6/1/12.

5) The DON will report outcomes
care plan reviews to the
quarterly Quality Improvement
Committee. The next QI
Committee meeting is
<table>
<thead>
<tr>
<th>F 280</th>
<th>The Administrator will report outcomes to the quarterly Board of Directors meeting. The next board meeting is scheduled for July 24, 2012.</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 315</td>
<td>NO CATHETER, PREVENT UTI, RESTORE BLADDER</td>
</tr>
<tr>
<td>F315</td>
<td></td>
</tr>
<tr>
<td>6/19/12</td>
<td></td>
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<tr>
<td>1)</td>
<td>The Facility will ensure residents who are incontinent of bladder receive appropriate treatment and services to prevent urinary tract infections and restore as much normal bladder function as possible.</td>
</tr>
<tr>
<td>2)</td>
<td>On 5/31/12, the DON observed Resident #5 on three occasions to ensure catheter bag was not touching the floor. On 6/1/12 the DON &amp; ADON conducted an in-service with all staff (RNs, LPNs &amp; CNAs) on Catheter care and proper placement of Foley catheter bags.</td>
</tr>
<tr>
<td>3)</td>
<td>On June 1, 2012, the DON and ADON observed all Residents with a Foley catheter to ensure catheter bags were not touching</td>
</tr>
</tbody>
</table>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
HUMPHREY'S CO NURSING HOME

STATE STREET, CITY, STATE, ZIP CODE
670 HIGHWAY 13 SOUTH
WAVERLY, TN 37185

(XI) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:
445489

(XII) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(XX) DATE SURVEY COMPLETED
05/31/2012

(XIV) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

F 315 Continued From page 5 drainage system for 1 of 3 (Resident #5) sampled residents with a Foley catheter.

The findings included:

Medical record review for Resident #5 documented an admission date of 12/19/06 with diagnoses of Osteoarthritis, Diabetes Mellitus, Neurogenic Bladder, Urinary Retention and Schizoaffective Disorder. Review of a physician's order dated 5/17/10 documented, "... #16 Fr [French] FIC Foley catheter] to BSB [bedside bag] [symbol for change] PRN as needed change BSB weekly..."

Observations in Resident #5's room on 5/29/12 at 10:17 AM and at 3:20 PM, revealed Resident #5 lying in bed with the Foley catheter BSB laying on the floor beside the bed.

During an interview in the Director of Nursing's (DON) office on 5/31/12 at 8:40 AM, the DON was asked what her expectation was for positioning the Foley catheter BSB when the resident is in bed. The DON stated, "...[BSB] should be hung on the side of the bed... off the floor..."

F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

F 315 the floor. CNAs and Licensed staff were in-serviced by DON on proper placement of catheter bag on 6/8/12 & 6/12/12.

4) To make sure that the deficient practice does not recur, DON will in-service all staff quarterly on proper placement of catheter bags beginning 6/19/12. The DON and Risk Manager will make random weekly Infection Control rounds to observe placement of catheter bags. The infection control monitoring checklist will be used to ensure compliance. This will begin 6/11/12 for (4) weeks or until 100% compliance is achieved.

5) The DON will report the outcomes of monitoring the placement of catheter bags at the next quarterly QI Committee meeting on July 3, 2012. The Administrator will provide a report to the quarterly Board of Directors meeting. The next board meeting will be July 24, 2012.

FORM CMS-2587(02-99) Previous Versions Obsolete
Event ID: SBU911
Facility ID: TN4322
If continuation sheet Page 6 of 13
This REQUIREMENT is not met as evidenced by:

Based on review of the manufacturer's instructions for the oxygen cylinder holder and observation, it was determined the facility failed to secure an oxygen cylinder for 1 of 6 (Resident #8) sampled residents and for Random Resident #1 who were receiving oxygen therapy.

The findings included:

1. Review of the manufacturer's instructions for the oxygen cylinder holder documented, "...Oxygen Cylinder Holder is designed to secure all 'D' and 'E' size oxygen cylinders to a standard wheelchair... Place oxygen cylinder in sleeve. Place top straps on push-handles and secure bottom straps to wheelchair frame (Fig. 4). Tighten all straps to limit movement of cylinder..."

2. Observations in the hallway area in front of the nurses' station on 5/30/12 at 11:16 AM, revealed Resident #8 seated in a reclined geri chair with an oxygen cylinder contained in an oxygen cylinder holder with the top straps attached to the push-handle. The bottom straps of the cylinder holder were not attached and secured to limit movement of the cylinder.

3. Observations in the east hallway on 5/30/12 at 11:45 AM, revealed Random Resident #1 seated in a wheelchair with an oxygen cylinder contained in an oxygen cylinder holder with the top straps attached to the push-handle. The bottom straps of the cylinder holder were not attached and secured to the wheelchair frame to limit movement of the cylinder.

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

On 5/30/12, Nursing staff replaced the oxygen cylinder holder for Resident #8 and attached and secured the straps on top and bottom. Nursing staff secured the bottom strap on Random Resident #1.

The DON, ADON and Risk Manager checked all resident's using oxygen e-tank holders and checked straps to ensure they were tightened. All licensed nursing staff was inserviced 6/8/12 & 6/12/12 on proper storage of E tanks when using on residents. A facility-wide in-service is also
<table>
<thead>
<tr>
<th>F 328</th>
<th>SS=E</th>
<th>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</th>
<th>F 323</th>
<th>scheduled on 6/19/12 on use of oxygen cylinder for RNs, LPNs, CNAs, PT, OT, and Activity staff members.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>The facility must ensure that residents receive proper treatment and care for the following special services:</td>
<td></td>
<td>4) Beginning 6/1/12, the DON, ADON, Risk Manager and Contract Respiratory Technician will check all oxygen cylinder holders at least twice monthly for the next 12 months.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</td>
<td></td>
<td>5) The DON will report E tank monitoring outcomes to the quarterly Quality Improvement Committee. The next QI Committee meeting is scheduled for July 3, 2012. The Administrator will report outcomes to the quarterly Board of Directors meeting. The next board meeting is scheduled for July 24, 2012.</td>
</tr>
</tbody>
</table>

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure oxygen (O2) was administered as ordered by the physician for 3 of 6 (Residents #7, 8 and 11) sampled residents receiving O2.

The findings included:

1. Review of the facility’s oxygen administration policy documented, "...Always check the chart for a physician’s order..."

2. Medical record review for Resident #7 documented an admission date of 7/5/11 with diagnoses of Chronic Obstructive Pulmonary Disease, Depression, Chronic Anemia and Chronic Back Pain. Review of the physician's orders dated 4/15/12 documented, "...O2 @ [at] 2 L [liter] / [per] M [minute] BNC (binaissi cannula)..."
<table>
<thead>
<tr>
<th>F 328</th>
<th>Continued From page 8</th>
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<tbody>
<tr>
<td><strong>Observations in Resident #7's room on 5/29/12 at 10:05 AM and at 3:30 PM, revealed Resident #7 receiving O2 per BNC at a rate of 1.5 L/M via O2 concentrator.</strong></td>
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<tr>
<td>During an interview in Resident #7's room on 5/31/12 at 8:30 AM, the Director of Nursing (DON) confirmed Resident #7 was receiving O2 per BNC at 1.5 L/M, not the prescribed rate of 2 L/M.</td>
<td></td>
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<tr>
<td>3. Medical record review for Resident #8 documented an admission date 12/18/06 with diagnoses of Mucopolysaccharidosis, Chronic Obstructive Disease, Bipolar Disease, Congestive Heart Disease and Seizure Disorder. The physician's order dated 5/15/12 documented, &quot;O2 @ 1L/Min [minute] nasal cannula continuous...&quot;</td>
<td></td>
</tr>
<tr>
<td><strong>Observations in Resident #8's room on 5/30/12 at 2:25 PM, revealed Resident #8's oxygen rate was set at 0.5 L/M.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Observations in Resident #8's room on 5/31/12 at 8:10 PM, revealed Resident #8's oxygen rate was set at 1.5 L/Min.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>During an interview in Resident #8's room on 5/30/12 at 2:25 PM, the DON confirmed the oxygen rate was set on 0.5 L/M, not at the physician's rate of 1 L/M.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>During an interview in Resident #8's room on 5/31/12 at 8:10 AM, Nurse #2 confirmed the oxygen was set on 1.5 L/M, not at the physician's prescribed rate of 1 L/M.</strong></td>
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</tbody>
</table>
| **F 328**

**Injections, parenteral and enteral fluids; colostomy, ureterostomy, or ileostomy care; tracheostomy care; tracheal suctioning; respiratory care; foot care; and prosthesis.**

**2) On 5/31/12, the DON, ADON and Risk Manager checked Resident #7, #8 and # 11 to ensure O2 was being administered as ordered by the physician.**

**3) On 5/31/12, DON, ADON and Risk Manager checked O2 rates on all other residents receiving supplemental O2 to ensure physician orders were being followed. A facility wide in-service will be conducted on 6/19/12 for all licensed nurses & CNAs by DON concerning following physician orders for O2 flow rates. This will be added to the standing orders for O2 & put on the MAR for O2 flow rate to be checked daily. (See attachment)**

**4) Beginning 6/1/12, the DON, or ADON will monitor monthly all residents who have oxygen...**
4. Medical record review for Resident #11 documented an admission date of 6/20/11 with diagnoses of Transient Ischemic Attacks, Anxiety, and Urinary Incontinence. The physician's order dated 1/22/12 documented, "...O2 @ 3 L/M via NC [nasal cannula] at HS [hour of sleep]..."

Observations in Resident #11's room on 5/31/12 at 8:00 AM, revealed Resident #11 receiving O2 per NC @ 1.5 L/M via NC.

During an interview in Resident #11's room on 5/31/12 at 8:30 AM, the DON confirmed Resident #11 was receiving O2 at 1.5 L/M. The DON confirmed the O2 was set at the incorrect rate and Resident #11 was to receive O2 at HS, not during the day.

5) The DON will report monthly reviews of O2 at correct rates to the quarterly Quality Improvement Committee. The next QI Committee meeting is scheduled for July 3, 2012. The Administrator will report outcomes to the quarterly Board of Directors meeting. The next board meeting is scheduled for July 24, 2012.

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 will employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
HUMPHREYS CO NURSING HOME

F 431
Continued From page 10
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 1970 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure medication was not stored past the expiration date in 1 of 4 (medication room) medication storage areas.

The findings included:
Observations in the medication room on 5/30/12 at 2:10 PM, revealed 4 bottles of liquid acetaminophen stored past the expiration dates of 1/11, 1/12 and 3/12.

During an interview in the medication room on 5/30/12 at 2:10 PM, Nurse #1 confirmed the 4 bottles of liquid Acetaminophen were stored past their expiration date.

During an interview in the Director of Nursing's (DON) office on 5/31/12 at 8:40 AM, the DON pharmacist who establishes a system of records of receipt and disposition of all controlled drugs and sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

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

2) Upon notification of expired drugs on 5/30/12, the Central Supply Nurse Manager removed the drugs with expiration dates. On 5/30/12 the DON in-serviced all the licensed staff working on the 7-3 shift concerning the deficient practice of not checking drugs for expiration dates when they are administering medications. On 6/8/12 & 6/12/12 an in-
**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**  
06/30/2012

| ID PREVIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | PROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY) | COMPLETION DATE |
|---------------|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------|
| F 431         | Continued From page 11  
was asked what would she expect the nurses to  
do with expired medications. The DON stated,  
"...discard them, throw them away..."  
F 498  
483.75(f) NURSE AIDE DEMONSTRATE  
COMPETENCY/CARE NEEDS  
The facility must ensure that nurse aides are able  
to demonstrate competency in skills and  
techniques necessary to care for residents'  
needs, as identified through resident  
assessments, and described in the plan of care.  
This REQUIREMENT is not met as evidenced  
by.  
Based on observation and interview, it was  
determined the facility failed to ensure 1 of 2  
Certified Nursing Assistants (CNA #1) practiced  
within their scope of proficiency when CNA #1  
turned an enteral feeding pump off while  
providing care.  
The findings included:  
Observations in Resident #5's room on 5/30/12 at  
11:05 AM, CNA #1 stopped the continuous tube  
feeding by putting the feeding pump on hold while  
providing personal care to Resident #5 and then  
restarted the tube feeding after completing care.  
During an interview in Resident #5's room on  
5/30/12 at 11:12 AM, CNA #1 was asked if the  
CNAs turned the pumps off during care. CNA #1  
confirmed they did.  
During an interview in the Director of Nursing's  
(DON) office on 5/31/12 at 8:40 AM, the DON  
was asked who would put the feeding pumps on  
service with all licensed staff  
on the policy Administration of  
Medication, including checking  
for expired drugs. (see  
attached)  
3) On 5/31/12 the DON, ADON,  
and Risk Manager checked all  
areas were drugs were stored  
for expiration dates.  
On 8/8/12 & 6/12/12 the DON  
&/or the ADON will conduct an  
in-service with all staff  
(RNs & LPNs) on checking for  
expired drugs.  
4) Beginning 6/1/12, the  
pharmacy consultant, DON, or  
ADON will monitor for  
expired drugs on a monthly  
basis in all areas that store  
drugs. The DON will conduct a  
quarterly in-service for all  
licensed staff on checking  
for expired drugs for the next 6  
months. This monitoring  
will continue for 6 months  
or longer until licensed staff  
have acquired 100%  

Continued from page 12

hold during care. The DON stated, "...only the nurses are supposed to [put feeding pumps on hold]."

F 498  F 431

compliance of their responsibilities.

5) The DON will report monthly the outcomes of the expired drug checks to the quarterly Quality Improvement Committee. The next QI Committee meeting is scheduled for July 3, 2012. The Administrator will report outcomes to the quarterly Board of Directors meeting. The next board meeting is scheduled for July 24, 2012.

F 498  F 498

NURSE AIDE
DEMONSTRATE
COMPETENCY/CARE
NEEDS

6/19/12

1) The facility will ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident
2) To correct the deficient practice on May 30, 2012, after CNA reported to DON she placed feeding tube on hold, CNA was immediately inserviced and instructed to notify Charge Nurse when care requires feeding to be held.

3) To protect other residents, DON started inservicing staff one-on-one regarding practicing within their scope of proficiency on 5/30/12 and completed 6/8/12. Another Facility wide in-service will take place on June 19, 2012 for RNs, LPNs & CNAs.

4) The DON and Risk Manager will randomly observe patient care on residents receiving enteral feedings per pumps beginning 6/11/12 on a weekly basis x 4 weeks, then monthly for a total of twelve (12) months. The DON will conduct quarterly in-services for all RNs, LPNs, & CNAs on...
5) Beginning 6/11/12 the DON will report the outcomes of the monitoring of enteral feeding pumps to the quarterly Quality Improvement Committee until 100% compliance has been achieved. The next QI Committee meeting is scheduled for July 3, 2012. The Administrator will report outcomes to the quarterly Board of Directors meeting. The next board meeting is scheduled for July 24, 2012.