STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

POC # 1

(1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER

445131

(2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(3) DATE SURVEY COMPLETED

C

10/22/2013

STREET ADDRESS, CITY, STATE, ZIP CODE

5321 BEVERLY PARK CIRCLE

KNOXVILLE, TN 37918

10/22/2013

NAME OF PROVIDER OR SUPPLIER

BEVERLY PARK PLACE HEALTH AND REHAB

(4) ID PREFIX TAG

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

ID PREFIX TAG

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

(5) COMPLETION DATE

1-L-4-13

F 281

483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:

Based on review of facility policy, observation, and interview, the facility failed to administer medication in accordance with the physician's orders for one resident (#9) of thirteen sampled residents.

The findings included:

Review of facility policy titled Administering Medications most recently revised in April 2007, and provided by the Director of Nursing on September 29, 2013, revealed, "...Medications will be administered in a safe and timely manner, and as prescribed...Medications must be administered in accordance with the orders, including any required time frame...The individual administering the medication must check the label THREE (3) times to verify the right medication, right dosage, right time...before giving the medication...must initial the resident's MAR (Medication Administration Record) on the appropriate line after giving each medication..."

Resident #9 was admitted to the facility on August 11, 2013, with diagnoses including Chronic Pain and Rheumatoid Arthritis.

Medical record review of physician orders dated August 11, 2013, revealed, "...Miralax Powder: 34 gm (grams) (cap is measure) in 16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Dwight J. Washington

FORM CMS-2567(02-99) Previous Versions Cancelled

Event ID: HGF111

Facility ID: TN4705

OCT 31 2016

It is continuing sheet Page 1 of 6
<table>
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<th>(X4) ID</th>
<th>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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<td>F 281</td>
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<td>0.5 oz (ounces) of water and take by mouth daily...Ropinirole...3 mg (milligrams)...take 1 tablet by mouth 2 times daily 3PM (3:00 p.m.) 8 PM (8:00 p.m.).</td>
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<td>Observation and interview with Registered Nurse (RN #1) on September 29, 2013, at 10:02 a.m., revealed Registered Nurse (RN #1) administered Miraxel 17 grams in approximately six ounces of water and Ropinirole 3 mg. to Resident #9.</td>
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<td>Review of the Medication Administration Record (MAR) and interview with RN #1 on September 29, 2013, at 11:23 a.m. In the main floor medication room, revealed the nurse had not initiated Ropinirole, and confirmed the medications had not been administered in accordance with the physician’s orders.</td>
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<td>F 323</td>
<td>483.25(h)</td>
<td>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</td>
<td>F 323</td>
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<td>SS=D</td>
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<td>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.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on medical record review, review of a facility investigation, observation, and interview, the facility failed to provide adequate supervision to prevent a fall for one resident (#3) of thirteen sampled residents.</td>
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<td>1. Resident #3 was assessed by the Charge Nurse on 07/14/2013 and by the Nurse Practitioner on 07/16/2013 with no negative outcome. The physician was notified on 07/14/2013 and a telephone order was received. The family was also notified on 07/14/2013. Resident #3 was evaluated by Physical Therapist for appropriate lift sling on 07/15/2013. The mechanical lift and the lift sling were evaluated by the Director of Facilities Management on 07/15/2013. Nurse Aides #1 and #2 were instructed on proper use of the total mechanical lift on 07/15/2013 by the Director of Nursing and Unit Manager.</td>
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<td>2. A 100% audit of resident lift assessments was completed 07/15/2013 – 07/18/2013 by the Director of Nursing, Assistant Director of Nursing and Unit Managers. No residents were found to be affected.</td>
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The findings included:

- Resident #3 was admitted to the facility on June 7, 2011, with diagnoses including Dementia with Behavioral Disturbance and Abnormality of Gait.

- Medical record review of a Minimum Data Set dated July 9, 2013, revealed the resident required assistance of two staff for transfers and had no history of falls.

- Medical record review of a care plan dated July 11, 2013, revealed, "...transfer...via total lift..."

- Medical record review of a physician’s order dated July 14, 2013, revealed, "Ice to bump on the head x (for) 24 hrs (hours)...."

- Review of a facility investigation report dated July 14, 2013, revealed, "...fell bump on head...Reported by (Certified Nursing Assistant - CNA #1)."

- Review of a witness statement by CNA #1 dated July 14, 2013, revealed, "(CNA #2) and I...changed (resident) and put the lift under (resident) and hooked (resident) up to the...lift...was positioning over the chair... (resident) came out of the lift..."

- Review of a witness statement by CNA #2 dated July 14, 2013, revealed, "(CNA #1) and I went...to change (resident) and to get (resident) out of bed. We hooked the sling onto the lift...lifted (resident) "

3. Nursing staff were re-instructed on proper use of the total mechanical lift by the Director of Nursing, Assistant Director of Nursing, Unit Managers, and Staff Development Coordinator on 07/15/2013-08/05/2013.

4. 100% of nurse aids will be observed for proper utilization of the total medical lift weekly x 3 months by the Director of Nursing, Assistant Director of Nursing and/or Unit Managers. Results of the findings will be reported to the Quality Assurance Performance Improvement Committee x 3 months or until 100% compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Therapy Manager, Staff Development Coordinator, Social Services Department, MDS Coordinators, Maintenance Director, Laundry Director, Admissions Director, Business Office Manager, Housekeeping Director, Medical Records, Dietary Manager, Activity Director, and Medical Director.
Continued From page 3
off the bed moved the lift away from the bed, As we were moving the lift toward (resident's) chair (resident) fell out of the sling onto the floor..."

Review of a facility investigation report dated July 14, 2013, revealed, "...3 of 4 sling straps connected..."

Medical record review of a Nurse Practitioner's note dated July 16, 2013, revealed, "F/U S/P: (follow up after) fall on 7-14-13. Neuro intact no hematoma...no significant trauma..."

Observation on September 29, 2013, at 1:23 p.m., revealed the resident seated in a wheelchair in the resident's room and two CNAs assisted the resident with oral hygiene.

Interview with CNA #1 on September 30, 2013, at 10:32 a.m. at a first floor nurse's station, revealed, "...after we cleaned (resident) we put lift pad under (resident)...positioned lift over (resident) to fasten it into lift. We buckled (resident) in..." Continued interview confirmed the resident fell from the lift during the transfer from the bed to a wheelchair on July 14, 2013.

C/O: #32057

F 441
483.66 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

Residents in room 102 were assessed by the Nurse Practitioner on 10/01/2013 with no negative outcome. Certified Nurse Aide #1 was instructed on proper handling and transportation of soiled linen on 10/01/2013 by the Staff Development Coordinator and/or Director of Nursing.
F 441 Continued From page 4
The facility must establish an Infection Control Program under which it:
(1) investigates, controls, and prevents infections in the facility;
(2) decides what procedures, such as isolation, should be applied to an individual resident; and
(3) maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection.
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which 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 review of facility policy, observation, and interview, the facility failed to transport linen to prevent the spread of infection on one floor (first) of four floors.

The findings included:

2. The Staff Development Coordinator completed competency check off for all certified nursing assistants on the handling and transporting of soiled linen on 10/22/2013 – 11/04/2013.
3. The Director of Nursing and/or Staff Development Coordinator re-inserviced nursing staff on proper handling and transportation of soiled linen on 10/01/2013-11/04/2013.
4. 10% of certified nursing assistants will be observed for proper handling and transportation of soiled linen weekly x 3 months by the Director of Nursing, Assistant Director of Nursing, and/or Unit Managers. Results of the findings will be reported to the Quality Assurance Performance Improvement Committee x 3 months or until 100% compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Therapy Manager, Staff Development Coordinator, Social Services Department, MDS Coordinators, Maintenance Director, Laundry Director, Admissions Director, Business Office Manager, Housekeeping Director, Medical Records, Dietary Manager, Activity Director, and Medical Director.
**F 441** Continued From page 5

Review of an undated facility policy provided by the Director of Nursing (DON) on October 1, 2013, and titled Linen Storage revealed, "...All personnel handling linen will follow linen storage guidelines...All contaminated laundry will be placed in specially marked laundry containers to reduce leakage...Soiled linen will be held away from the body and transported directly to the appropriate linen hamper. Never place soiled linen on the floor...Transport in the linen bag..."

Observation on September 29, 2013, at 9:32 a.m., revealed Certified Nursing Assistant (CNA) #1 exited Room 104, carried a plastic bag filled with white material in each hand and walked past room 102. Continued observation revealed CNA #1 turned around, carried the bags, and entered Room 102.

Interview with CNA #1 on September 29, 2013, at 9:35 a.m., revealed one bag contained bed linen used by a resident in Room 104 and the other contained soiled briefs. Continued interview revealed the CNA was aware of the appropriate method for handling used linen and soiled briefs.

Interview with the Director of Nursing (DON) on October 1, 2013, at approximately 1:00 p.m., in the DON's office, confirmed the facility failed to transport linen in a manner to prevent the spread of infection.