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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 225</td>
<td>SS=D</td>
<td>483.13(c)(1)(ii)-(iii), (c)(2) - (4)</td>
<td>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</td>
<td>F 225</td>
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This provider submits the following plan of correction in good faith and to comply with Federal Law. This plan is not an admission of wrong doing nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies.

An investigation was re-conducted on the incident with RR #1 by the Current Director of Nursing on 7-3-10 and resubmitted to the state agency unusual incident reporting system; there were no findings of alleged abuse.

No other residents were identified that required investigation of alleged abuse or reporting of incidents at this time.

All alleged abuse/incident of unknown origin will continue to be investigated by the Director of Nursing and entered on a log in the Administrator's office.
F 225 Continued From page 1
This REQUIREMENT is not met as evidenced by:
Based on policy review and interview, it was determined the facility failed to thoroughly investigate an incident of alleged abuse or report the alleged abuse to the State agency Unusual Incident Reporting System (UIRS) as required for 1 of 1 allegation of abuse reviewed.

The findings included:
Review of the facility's "Abuse and Neglect - Clinical Protocol" policy documented, "Our facility will not condone resident abuse by anyone... "Abuse" means the willful infliction of injury... intimidation, or punishment... The staff, with the physician's input, will investigate alleged occurrences of abuse... The Administrator... will appoint a member of management to investigate... The Administrator will provide to the person in charge... a completed copy of the Report Form... the investigation will, as a minimum... interview the person(s) reporting the incident... interview any witnesses to the incident... interview the resident... interview the staff members... interview... family members, and visitors... Review all events leading up to the alleged Incident... Witness reports will be reduced to writing... The Administrator will provide a written report of the results of all abuse investigations and appropriate action taken to the state survey and certification agency... within five (5) working days of the reported incident."

Medical record review for Random Resident (RR) #1 documented an admission date of 6/1/10 with diagnoses of Benign Neoplasm, Alzheimer's Disease, Hypertension, Seizures, Pain, and Nausea. Nurses' notes dated 4/30/10 at 1630

F 225 The Director of Nursing or Designee and Administrator will monitor allegations of abuse and investigate and report to the State Agency within required timeframe.
Data from the log will be tracked and trended by the Administrator and presented to the Quality Assurance and Assessment (QA&A) Committee for 3 months.

The QA&A Committee will determine the need for continued tracking and trending frequency of the log at this time if 100% compliance has been met.
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</table>
| F225 | Continued from page 2 (4:30 PM) documented "Spoke to Mrs. [name of RR #1's wife] about the abuse that has been alleged against her toward her husband. She [RR #1's wife] stated that I [last Director of Nursing (DON) who wrote this note] was correct & [and] stated that she had tried to force him [RR #1] to eat & then slapped his hands when he attempted to eat the food that he had spit onto his plate. She [RR #1's wife] stated "I didn't know what else to do to stop him from eating the food that he had spit onto his plate." I [last DON who wrote this note] explained that we take allegations of abusive behavior very seriously, & needed to do a complete investigation. She [RR #1's wife] would be required to have supervision when visiting him..."

Review of a statement signed by the Certified Occupational Therapy Assistant (COTA #1) documented, "On April 30, 2010 at about 12 noon I [COTA #1] was walking down the hallway passing patient's room 102, [named RR #1]. I [COTA #1] noticed [named RR #1's wife] being aggressive, verbally abusive (yelling) and shoving food into patient's [patient's] mouth. I [COTA #1] took a second look and walked into the room, I asked if she [RR #1's wife] needed help but she was very frustrated, appeared angry and continued to yelling [yell] at the patient [RR #1]. [Named RR #1] appeared to be choking but he was just spitting the food out of his mouth. [Named RR #1] proceeded to reach [reach] for the food with his right hand when Mrs. [named RR #1's wife] slapped his [RR #1's] hand overly aggressive several times. I [COTA #1] asked her [RR #1's wife] to give him [RR #1] some time that maybe he will be hungry later. I [COTA #1] reported the incident to my immediate supervisor [supervisor's name] who recommended informing..."
F 225
Continued From page 3
the DON [named former DON]. [Former] DON asked to write summary of what I [COTA #1] witnessed.""

The facility was unable to provide documentation of a thorough investigation into the 4/30/10 incident of alleged abuse by not having an incident report and statements from staff, residents or visitors. The facility had not submitted the 4/30/10 alleged abuse incident to the Unusual Incident Reporting System (UIRS) as required.

During an interview in the Director of Nursing Office (DON) on 6/23/10 at 11:15 AM, the Regional Clinical Coordinator stated, "That is all of the file we can find. I was here on 4/30/10 when the last DON left a message report on the phone with the state office because she could not log onto the website."

During an interview in the DON's office on 6/23/10 at 11:15 AM, the DON verified that was all of the incident they could find.

During an interview in the conference room on 6/23/10 at 11:25 AM, the Administrator stated, "The report was called into the state on 4/30/10 because she [DON] couldn't get it done on the computer."

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.

7/22/10
The Director of Nursing reinforced licensed nurses #2, and #3 on the policy of knocking on doors to gain permission to enter.

Supervisor reminded licensed nurses to knock on doors when passing medications to gain permission to enter.
<table>
<thead>
<tr>
<th><strong>F 241</strong> Continued From page 4</th>
<th><strong>F 241</strong> Ongoing observation will be done by facility management team to identify any resident that is put at risk by any nurse not knocking before entering and will report this information to DNS and/or Administrator at time of occurrence.</th>
</tr>
</thead>
<tbody>
<tr>
<td>This REQUIREMENT is not met as evidenced by:</td>
<td>Re-education to licensed nursing staff on resident dignity including knocking on doors when passing medication to gain permission to enter will completed by SDC or designee on or before July 21, 2010.</td>
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<tr>
<td>Based on review of the medication guide for the long-term care nurse and observations, it was determined the facility failed to ensure 2 of 6 (Nurses #2 and 3) nurses maintained the resident's dignity and respect by entering resident rooms without knocking or gaining permission prior to entering room during the medication administration pass.</td>
<td>Upon hire and bi-yearly, resident rights and dignity inservices will be completed by the SDC or designee for all staff.</td>
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<tr>
<td>The findings included:</td>
<td>Observation results will be reported by the DON or designee and presented at the monthly Quality Assurance and Assessment (QA&amp;A) meeting for 2 months.</td>
</tr>
<tr>
<td>1. Review of the medication guide for the long-term care nurse, sixth edition page 68 documented, &quot;...11. The nurse should knock on the resident's door before entering and positively identify the resident before giving the medications...&quot;</td>
<td>The QA&amp;A Committee will determine the need for continued audit frequency at this time if 100% compliance has been met.</td>
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<tr>
<td>2. Observations on the 500 hall on 6/21/10 at 4:38 PM, revealed Nurse #3 entered room 520 four times without knocking or gaining permission to enter.</td>
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<td>Tag</td>
<td>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</td>
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<td>--------------------------------------------------------------------------------------------------</td>
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<tr>
<td>F 241</td>
<td>Continued from page 5 knocking or gaining permission to enter. 483.20(d)(3), 483.10(k)(2) Right to Participate Planning Care-Revise CP</td>
</tr>
<tr>
<td>F 280</td>
<td>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment. 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>
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<td>This REQUIREMENT is not met as evidenced by: Based on medical record review and an interview, it was determined the facility failed to revise the comprehensive care plan to reflect the residents' current status for emergency bleeding for 2 of 15 (Residents #7 and 11) sampled residents.</td>
</tr>
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<td>The findings included: 1. Medical record review for Resident #7 documented an admission date of 4/5/10 and a re-admission date of 5/17/10 with diagnoses of</td>
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| F280 | | Continued From page 6  
End Stage Renal Disease, Hemodialysis, Diabetes, Tachycardia, Obesity and Blindness. Review of the care plan dated 4/15/10 and updated 6/4/10 documented, "Assess shunt sites for bleeding." The care plan did not address measures to be put in place to stop emergency bleeding.  
2. Medical record review for Resident #11 revealed an admission date of 5/27/10 with diagnoses of Acute Osteomyelitis, End Stage Renal Disease, Cerebrovascular Disease, Hemodialysis, Hypertension, Diabetes and Congestive Heart Failure. Review of the care plan dated 5/27/10 documented "...assess shunt locations for bruit [bruit] and thrill, bleeding. notify md [medical doctor]." The care plan did not address measures to be put in place to stop emergency bleeding.  
During an interview in the Minimum Data Set (MDS) office on 6/23/10 at 10:45 AM, the MDS Nurse stated, "I don't know if I would write that on the care plan... I thought we all knew emergency procedure [for emergency bleeding]... we are trained to do these things... I did not specify to apply pressure [on the care plan]." | F280 | | | |
| F282 | SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  
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 | F282 | | | 7/22/10

The QA&A Committee will determine the need for continued audit frequency at this time if 100% compliance has been met.

Resident #1 has the heels floating and bed alarm implemented as identified in plan of care.

Resident #7 has the personal alarm and floor mat implemented as identified in plan of care.

All residents with care plan interventions for heel floats and or alarm devices were reviewed to ensure that care plan interventions had been implemented.
### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>(X1) Provider/Supplier/CLA Identification Number</th>
<th>(X2) Multiple Construction</th>
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<tbody>
<tr>
<td>445482</td>
<td>A. BUILDING</td>
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<td></td>
<td>B. WING</td>
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</tbody>
</table>

#### Name of Provider or Supplier

RIPLEY HEALTHCARE AND REHAB CENTER

#### Street Address, City, State, Zip Code

118 HALLBUTON DRIVE

RIPLEY, TN 38063

#### Date Survey Completed

06/23/2010

### F 282

**Continued From page 7**

And interview, it was determined the facility failed to follow the care plan interventions for body alarm, floating heels or mats at bedside for 2 of 13 (Residents #1 and 7) observed sample residents.

The findings included:

1. Medical record review for Resident #1 documented an admission date of 12/21/09 with a re-admission date of 2/6/10 with diagnoses of Traumatic Fracture Hip, Chronic Airway Obstruction, Senile Dementia and Gastrostomy Status. Review of a care plan dated 5/7/10 documented, "Problem: SELF-CARE DEFICIT... APPROACH... Float heels in bed... Problem: POTENTIAL FOR INJURY R/T [related to] FALL RISK STATUS... APPROACH... Body Alarm..."

Observations in Resident #1's room on 6/21/10 at 9:29 AM, revealed Resident #1 lying in bed, her heels were not floating and there was no body alarm in place as care planned.

Observations in Resident #1's room on 6/22/10 at 8:05 AM and 8:30 AM, revealed Resident #1 lying in bed, her heels were not floating and there was no body alarm in place as care planned.

Observations in Resident #1's room on 6/23/10 at 7:40 AM, revealed Resident #1 lying in bed and her heels were not floating as care planned.

During an interview in Resident #1's room on 6/22/10 at 8:30 AM, Nurse #1 confirmed that Resident #1 was not wearing a body alarm and her heels were not floating as care planned.

2. Medical record review for Resident #7

#### F 282

Re-education will be completed by the SDC on or before July 22, 2010 for licensed staff and nursing assistants on the importance of ensuring resident interventions on plan of care are consistently implemented.

The Director of Nursing or Designee will audit 3 residents weekly to ensure that care plan interventions have been implemented accordingly for two months.

The findings of the audits will be brought to the monthly Quality Assurance and Assessment (QA&A) Committee meeting by the DON or designee for 2 months.

The QA&A Committee will determine the need for continued audit frequency at this time if 100% compliance has been met.
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<td>F 282</td>
<td>Continued From page 8 documented an admission date of 4/5/10 and a re-admission date of 6/17/10 with diagnoses of End Stage Renal Disease, Diabetes, Obesity, Hemodialysis, Tachycardia, and Blindness. Nurses's notes documented that Resident #7 had falls with no injuries on 4/11/10, 4/28/10 and 4/28/10. The care plan updated on 6/4/10 documented, &quot;POTENTIAL FOR INJURY R/T FALL RISK STATUS... Approach... 8. Personal Alarm... 13. Matt [mat] on L [left] side of bed...&quot; Observations in Resident #7's room on 6/21/10 at 5:15 AM and on 6/22/10 at 7:50 AM, 11:00 AM, 12:10 PM, 2:05 PM and 4:05 PM, revealed Resident #7 seated in a wheelchair (w/c) without a personal alarm in place as care planned. Observations at the 100-400 Nurses' station on 6/22/10 at 10:00 AM and 4:35 PM, revealed Resident #7 seated in a w/c without a personal alarm in place as care planned. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:</td>
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<td>F 309</td>
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| COMPLETION DATE | 7/22/10 |

Resident #3
New orders have been obtained for hospice care.

Any resident currently receiving hospice services had orders reviewed and clarified to ensure current orders reflect hospice services.

The SDC or designee will complete re-education on or before 7/22/10 with licensed nurses on the need for receiving and transcribing hospice orders.

The Director of Nursing or designee will review hospice orders weekly for 2 months to monitor accuracy.
**F 309** Continued From page 9

Based on medical record review and interview, it was determined the facility failed to obtain a current order for hospice care for 1 of 15 (Resident #3) sampled residents.

The findings included:

Medical record review for Resident #3 documented an original admission date of 6/24/07 and a readmission date of 3/23/10 with diagnoses of Cardiac Dysrhythmia, Diabetes, Depressive Disorder, Anxiety, Aphasia Due to Cerebral Vascular Accident, Seizure Disorder, Hypothyroidism, Senile Dementia and hospice care. The current physician's orders dated 6/1/10 did not include an order for hospice care.

During an interview at the 100-400 nurses' station on 6/21/10 at 2:00 PM, Nurse #4 stated, "[Resident #3] is on Hospice..."

During an interview at the 100-400 nurses' station on 6/21/10 at 3:30 PM, after reviewing Resident #3's chart, Nurse #9 stated, "no current hospice order... last hospice order was 3/23/10..."

**F 315** 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

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

**F 309** The hospice order review results will be brought to the monthly Quality Assurance and Assessment (QA&A) Committee meetings by the DNS or designee for 2 months.

The QA&A Committee will determine the need for continued review frequency at this time if 100% compliance has been met.

Resident #2 will receive pericare following appropriate infection control practices.

C.N.A. #1 was re-inservices on the proper procedure for pericare by the SDC on 6-5-10 for resident #2.
### F 315

**Continued From page 10**

This REQUIREMENT is not met as evidenced by:

Based on review of the “CNA [Certified Nursing Assistant] Candidate Handbook”, observation and interview, it was determined the facility failed to ensure that pericare was performed according to training and standards for nurse aides to prevent a urinary tract infection for 1 of 3 (Resident #2) residents observed receiving pericare.

The findings included:

- Review of the "CNA Candidate Handbook" Version 4.5 October 2009, Skill #20 - Perineal Care for a female" documented, "...cleans one side of labia from top to bottom using a clean portion of a washcloth with each stroke. Cleans other side... using a clean portion of a washcloth with each stroke."

- Observations in Resident #2's room on 6/22/10 at 8:45 AM, revealed CNA #1 performed pericare on Resident #2. CNA #1 was observed to wet a washcloth at the sink... wiped front to back on right side of labia, wiped again front to back on right side with same area of washcloth. CNA #1 then wiped twice front to back on left side of labia with the same side of washcloth, wiped the middle front to back twice with the same area of the washcloth without changing the side of the washcloth during the entire procedure.

- During an interview at the 100-400 nurses' station on 6/22/10 at 11:00 AM, CNA #1 was asked about inservices on pericare. CNA #1 stated, "No pericare in-services since I have been here."

### F 315

The Unit Manager or designee will observe pericare on each unit to identify other residents having the potential to be affected on or before July 22, 2010.

An inservice on pericare will be completed on or before 7-22-10 by the SDC or designee for licensed nursing staff and CNA.

C.N.A. will complete a return demonstration competency for pericare with the SDC or designee on or before 7/22/10

The Director of Nursing or designee will review pericare skilled competencies that have been completed weekly until all nursing assistants have successfully demonstrated the competency. The progress of completion of pericare competencies will be brought to the monthly Quality Assurance and Assessment (QA&A) meeting and reviewed by the DNS or designee until all CNA competencies have been complete.
**F 322** Continued From page 11

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and naso-pharyngeal ulcers and to restore, if possible, normal eating skills.

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 staff did not crush non-crushable medications; failed to dissolve crushed medications in liquid and failed to ensure Percutaneous Endoscopic Gastrostomy (PEG) tube feedings ran continuously as ordered for 2 of 5 (Residents #1 and 5) sampled residents with PEG tubes.

The findings included:

1. Review of the facility's "Enteral Nutrition" policy documented, "...Enteral feeding orders will be written to ensure consistent volume infusion. The following information will be included to ensure that the full volume will be infused, regardless of any interruption of feeding: a. Pump Feeding (1) Product name; (2) Type of tube; (3) Rate of infusion (number of ml [milliliters] per hour); (4) Total calories per day; (5) Start time; and (6) Total daily volume to be infused (number of ml per day)".

2. Review of the facility's "Administering Medications through an Enteral Tube" policy

| **F 322** | Resident #1 All enteral medicines will be administered per policy. Resident #1 will receive nutritional feeding per MD order. New physician orders obtained to accommodate activities without feeding.

Nurse #1 was re-educated on the procedure for medication administration through an enteral tube and the "Do Not Crush Medication List".

Resident #5 will receive nutritional feeding per MD order.

Nurse #5 was re-educated by the Director of Nursing on following physician's orders.

Resident orders for enteral feedings will be reviewed by the Registered Dietician to identify enteral feeding orders that need to be changed to accommodate activities.
F 322  Continued From page 12 documented, "...2. Do not crush or split medications for administration through an enteral tube unless first checking with the pharmacy or facility approved "Do Not Crush Medication List." Do not crush enteric coated, sustained release, buccal, sublingual, or enzyme specific medications... 4. Dilute medications and flush the tube with room temperature or warm liquids..."

Medical record review for Resident #1 documented an admission date of 12/21/09 with a re-admission date of 2/6/10 with diagnoses of Traumatic Fracture Hip, Chronic Airway Obstruction, Senior Dementia and Gastrostomy Status. Review of a physician's order dated 6/8/10 documented, "Give Isosource 1.5 @ [at] 50cc [cubic centimeters] hr [hour] x [times] 24 hours."

Observations in Resident #1's room on 6/21/10 at 9:29 AM, revealed Nurse #1 administered Theravita 5 cc's, Xanax 0.5 mg, Prevacid 30 mg, Effexor 75 mg and Cardizem 30 mg to Resident #1 per PEG tube. Nurse #1 crushed the Prevacid which was a Solutab-Delayed Release tablet and did not dilute the crushed medications with a liquid prior to administering them to Resident #1.

Observations in Resident #1's room on 6/21/10 at 9:29 AM, and on 6/22/10 at 8:05 AM, revealed Resident #1 was receiving a feeding of Isosource 1.5 Cal [calories] at 55cc/hr per PEG tube.

During an interview in Resident #1's room on 6/22/10 at 8:30 AM, Nurse #1 stated, "It [referring to tube feeding] should be going at 50cc/hr."

Observations on the 500 hall on 6/21/10 at 2:30 PM, revealed Resident #1 seated in a wheelchair.

Medication will be administered for residents with enteral tubes per the Administering medication through and enteral tube policy.

No residents were found to be adversely affected as a result of the concerns noted.

An inservice on medication administration per an enteral tube; following physician orders and the "Do Not Crush Medication List" will be completed by the SDC or designee on or before July 22nd, 2010 for licensed nursing staff.

Licensed nurses will complete a return demonstration competency on medication administration per enteral tube with the SDC or designee on or before July 22nd, 2010.

The Director of Nursing or designee will review the medication administration per enteral tube competencies that have been completed weekly until all licensed nurses have successfully demonstrated the competency.
**F 322** Continued From page 13

(w/c) outside her room without tube feeding infusing.

Observations in the activity room on 6/21/10 at 3:00 PM, revealed Resident #1 seated in a w/c without the tube feeding infusing. Resident #1 attended the group meeting from 3:00 PM until 3:30 PM without her tube feeding infusing.

Observations on the 600 hall on 6/21/10 from 3:30 PM until 5:00 PM, revealed Resident #1 seated in a w/c going up and down the hallway without her tube feeding infusing.

During an interview in the conference room on 6/22/10 at 2:45 PM, the Dietary Manager stated, "They are going to have to let her feeding go as they should. Have order for feeding to be off during therapy, but still have to make adjustments. We realize it's a big problem and I have started working on it. I will have the Dietitian evaluate her immediately within the next 20 minutes."

3. Medical record review for Resident #5 documented an admission date of 5/2/10 with diagnoses of Dysphagia, Hypertension, Anemia, Cerebrovascular Accident and Coronary Artery Disease. Review of the admission orders dated 5/14/10 documented "...Novasource Renal @ 80 cc / [per] hr x 20 Hours on 5 pm off 1 pm..."

Observations in Resident #5's room on 6/21/10 at 2:00 PM and on 6/22/10 at 2:30 PM, revealed Resident #5 was receiving a feeding of Novasource Renal infusing at 50 cc/hr per PEG tube. The feeding should have been completed at 1 PM on 6/21 and 6/22/10.

The process of completion of the medication administration per enteral tube competencies will be brought to the Quality Assurance and Assessment (QA&A) meeting by the Director of Nursing or designee until all licensed nurses have completed competency successfully.
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<th>COMPLETION DATE</th>
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<tr>
<td>F.322</td>
<td>Continued From page 14 During an interview at the 500 Hall Nurses Station on 6/22/10 at 5:55 PM, Nurse #5 stated &quot;I do not know why feeding not being turned off, I have not had time to get to this end today.&quot;</td>
<td>F.322</td>
<td>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.</td>
<td>7/22/10</td>
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| F.323         | Resident #9 was reassessed by the interdisciplinary team on July 5th, 2010 for appropriate fall interventions for a confused resident.  
The intervention was placed on the Care Plan and Certified Nursing Assistant ADL sheets.  
Residents that have cognitive impairment and or a history of falls will be reassessed by the interdisciplinary team to ensure fall prevention interventions are appropriate for confused residents.  
All licensed staff and Certified Nursing Assistants will be reinsinced by the SDC or designee on or before July 22, 2010 regarding appropriate fall interventions for confused residents.  
Interventions will be placed on the TARS and Certified Nursing Assistants Care Cards. |
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<tr>
<td>F323</td>
<td>Continued From page 15</td>
<td><strong>Injuries on 3/22/10, 3/15/10 and 5/7/10.</strong></td>
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<td>Review of Resident #9's care plan dated 3/24/09 and updated 4/12/10 documented, &quot;Alert c [with] confusion. Will complete ADL's [Activities of Daily living] c supervision to min [minimum] assist. Reminded frequently to use call bell for help although usually will not... AT RISK FOR FALLS D'T [due to] MED [medication] THERAPY AND MOBILITY LIMITATIONS WITH IMPAIRED DECISION MAKING... 4/12/10 Actual (3/15 and 3/24/10)... Reminded to use call bell for assist...&quot; The fall that occurred on 5/7/10 was not documented on the care plan nor were new interventions put in place to prevent further falls.</td>
<td>F323</td>
<td>Falls will be monitored by the Director of Nursing and/or Designee for proper intervention post falls during the weekly interdisciplinarty teams meeting for 3 months.</td>
<td>7/22/10</td>
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<td>Review of the Post Fall Evaluation for Resident #9 dated 3/15/10 documented, &quot;...need for redirecting her to turn on call light to get assistance to get OOB [out of bed] or OOWC [out of wheelchair].&quot; Review of the Post Fall Evaluation for 3/22/10 documented, &quot;We encourage use of call light to get assistance to get OOB or OOWC. The interventions put in place after the 3/15 and 3/22/10 falls were not appropriate interventions for a confused resident.</td>
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<td>Review of the Post Fall Evaluation for 5/7/10 documented, &quot;...had extra pillow in her chair and lost her balance and sat on the floor.&quot; There was no new intervention put in place to prevent further falls.</td>
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<td>Observations in Resident #9's room on 6/21/10 at 9:40 PM; revealed Resident #9 was alert but confused.</td>
<td>F325</td>
<td>483.25g) MAINTAIN NUTRITION STATUS SS=0 UNLESS UNAVOIDABLE</td>
<td>F325</td>
<td><strong>Res #5 will be weighed for 3 days to establish a consistent &amp; accurate weight.</strong></td>
<td>7/22/10</td>
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<td><strong>Res #7 will be weighed daily per physician's order.</strong></td>
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<td><strong>Res #10 Will be weighed for 3 days to establish a consistent &amp; accurate weight.</strong></td>
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**Form CMS-2587(02-09) Previous Version is Obsolete**  
Event ID: 705401  
Facility ID: TN14003  
If continuation sheet Page 16 of 33
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

<table>
<thead>
<tr>
<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
<th>PROVIDER/SUPPLIER IDENTIFICATION NUMBER</th>
<th>MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>(X1)</td>
<td>445492</td>
<td>(X3) DATE SURVEY COMPLETED</td>
</tr>
<tr>
<td>(X3)</td>
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<td>06/23/2010</td>
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</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**  
**RIPLEY HEALTHCARE AND REHAB CENTER**

<table>
<thead>
<tr>
<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
</table>
| 116 HALLBURTON DRIVE RIPLEY, TN 38063|               | F 325 Continued From page 16  
Based on a resident's comprehensive assessment, the facility must ensure that a resident -  
(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and  
(2) Receives a therapeutic diet when there is a nutritional problem.  
This REQUIREMENT is not met as evidenced by:  
Based on policy review, medical record review, and interview, it was determined the facility failed to ensure accurate weights were obtained and daily weights were performed as ordered for 3 of 16 (Residents #5, 7 and 10) sampled residents.  
The findings included:  
1. Review of the facility's "Weight Assessment and Intervention" policy documented "...Weight Assessment: 1. The nursing staff will measure resident weights on admission, the next day, and weekly for two weeks thereafter..."  
2. Medical record review for Resident #5 documented an admission date of 5/2/10 with diagnoses of Dysphagia, Hypertension, Anemia, Cerebrovascular Accident, and Coronary Artery Disease. Review of the weight records documented an admission weight of 170 pounds (#), Review of the weight records documented an admission weight of 170 pounds (#), Review of the nutritional progress notes documented 5/4/10 "...Ht [height] & [and] Wt [weight] not available-will request...", 6/14/10 "...wt 142#, requesting reweigh verifying..." and 6/15/10 |

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<tr>
<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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<tbody>
<tr>
<td>All residents will be reweighed by July 10th, 2010. Any significant weight gain or loss will require the resident to be reweighed to ensure accurate weight was obtained.</td>
<td>7/22/10</td>
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</table>

No other residents were identified with orders to weigh daily.  
Re-education will be completed by the SDC or designee on or before July 22, 2010 to licensed nurses and Certified Nursing Assistants on obtaining and documenting weights accurately.  
Scales will be calibrated and placed in a permanent area.  
The weights will be reviewed weekly during the interdisciplinary team meeting by the DNS or designee to ensure weights and reweights were obtained and documented accurately.  
The findings of the review will be brought to the monthly Quality Assurance and Assessment meeting by the Director of Nursing or designee for 3 months.
**F 325**  
Continued From page 17  
"Re-weight of 158.8#..." No other weights were documented.

On 6/22/10 at 3:00 PM, the surveyor requested that the facility reweigh Resident #5. The staff calibrated the scale and weighed Resident #5. Resident #5's weight was 172.4#.

During an interview at the 100-400 nurses' station on 6/22/10 at 4:25 PM, the Director of Nursing (DON) stated, "Residents should be weighed within 24 hours of admit, then every day for 3 days, then weekly for 4 weeks, then monthly if stable." The DON confirmed Resident #5 was not weighed as required.

The facility failed to ensure accurate and weekly weights were performed for Resident #5.

3. Medical record review for Resident #7 documented an admission date of 4/5/10 and a re-admission date of 5/17/10 with diagnosis of End Stage Renal Disease, Diabetes, Obesity, Hemodialysis, Tachycardia and Blindness. Review of admission orders dated for 5/17/10 documented, "...Daily Wts. [weights]..." The Physician's orders dated 5/9/10 documented, "...DAILY WEIGHTS..." The facility was unable to provide daily weights for 6/4/10, 6/5/10, 6/6/10, 6/7/10 and 6/11/10.

During an interview at the 100-400 nurses' station 6/23/10 at 10:25 AM, Nurse #11 stated, the 11-7 nurse is suppose to obtain the weights and confirmed the daily weights were not done for Resident #7 as noted above.

4. Medical record review for Resident #10 documented an admission date of 3/26/10 with...
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<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>POS COMPLETION DATE</th>
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<tr>
<td>F 325</td>
<td>Continued from page 18 diagnoses of Dysphagia, Muscle Weakness, Cerebral Vascular Disease and Hypertension. Resident #10's weights were documented as 134.4# on 3/25/10 (resident was not admitted until 3/28/10); 113# on 4/1/10; 114.2# on 5/1/10; 204.4# on 5/24/10 and 115.4# on 6/1/10. Observations in the nursing lounge area on 9/23/10 at 10:00 AM, revealed Resident #10 being weighed with an actual weight of 118.8 lbs. During an interview in the conference room on 5/23/10 at 10:00 AM, when shown the weights for Resident #10 the Registered Dietitian stated, &quot;That's an error [204.4 weight], she [Resident #10] should have been re-weighed.&quot;</td>
<td>F 326</td>
<td>The oxygen level for resident #2 was adjusted to MD order on 06/23/2010 and nurse #7 and #10 as well as other nursing staff will be re-educated to ensure residents receive O2 per physician’s orders; the resident had no adverse effects.</td>
<td>7/22/10</td>
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<td>F 328</td>
<td>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, urostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and interviews, it was determined the facility failed to provide proper respiratory care by not administering oxygen (O2) at the rate prescribed by the physician for 2 of 4 (Residents #2 and 10)</td>
<td>F 328</td>
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All residents with orders for O2 were observed on 6/5/10 by the Unit Manager in regards to O2 being received per physician order’s; no other resident identified.
Continued From page 19

sampler residents with O2 in use.

The findings included:

1. Medical record review for Resident #2 documented an admission date of 1/31/07 and readmission date of 1/31/10 with diagnoses of Chronic Obstructive Bronchitis, Diabetes Mellitus, Rheumatoid Arthritis, Osteoporosis, Senile Dementia, Hypertension and Depression. Review of a physician’s order dated 8/1/10 documented, “O2 1.5 L [liter] BNC [binaissal cannula] continuous [continuous].”

Observations in Resident #2’s room on 6/21/10 at 9:24 AM, on 6/22/10 at 2:20 PM and on 6/23/10 at 7:40 AM, revealed Resident #2 receiving O2 at 2.0 liters per minute (L/M).

Observations in Resident #2’s room on 6/21/10 at 10:35 AM and 1:55 PM and on 6/23/10 at 10:35 AM revealed Resident #2 receiving O2 at 2.5 L/M.

During an interview at 100-400 nurses’ station on 6/23/10 at 7:43 AM, Nurse #10 stated, “Every shift every body is to check O2 for correct liter.”

During an interview in Resident #2’s room on 6/23/10 at 10:35 AM, Nurse #7 stated, “It [Resident #2’s oxygen] is set at 2.5 L.”

During an interview in the conference room on 6/23/10 at 11:45 AM, Nurse #7 stated, “Yes, I see on the orders it [oxygen] is [prescribed at] 1.5 L/M.”

2. Medical record review for Resident #10 documented an admission date of 3/26/10 with diagnoses of Dysphagia, Muscle Weakness,
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEC IDENTIFYING INFORMATION)</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<td>F 328</td>
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<td>Continued From page 20 Cerebral Vascular Disease and Hypertension. Review of a physician’s order dated 6/19/10 documented, “...O2 BNC at 2L/MIN...” Observations in Resident #10’s room on 6/21/10 at 9:20 AM and on 6/23/10 at 7:40 AM, 11:15 AM and 11:40 AM, revealed Resident #10 lying in bed receiving O2 at 3.5 L/M. 3. The facility failed to ensure Residents #2 and #7 received oxygen at the physician’s prescribed rate. 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 policy review, medical record review, observations and interview, it was determined the facility failed to ensure 3 of 6 (Nurses #1, 2 and 3) nurses administered medications without a medication error rate of less than 5 percent (%). A total of 3 errors was observed out of 42 opportunities for error, resulting in a medication error rate of 7.14%. The findings included: 1. Review of the facility’s “Administering Medications through an Enteral Tube” policy documented, “...2. Do not crush or split medications for administration through an enteral tube unless first checking with the pharmacy or facility approved “Do Not Crush Medication List.”</td>
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<td>7/22/10</td>
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<td>F 332</td>
<td>Ss=d</td>
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<td>Resident #1, #13 and #5 were assessed for potential negative outcome due to the concerns noted and no adverse affect was identified. Nurse #1 was re-educated on the “DO NOT CRUSH MEDICATION LIST” for resident #1. Nurse #2 was re-educated on diluting KCL with water per physician’s order for resident #13. Nurse #3 was instructed to flush peg tube with H2O per physician order before and after enteral medication for resident #5. The SDC or designee will observe medication administration per enteral tube on each unit to identify other residents having the potential to be affected on or before July 22, 2010.</td>
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<td>7/22/10</td>
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<td>ID PREFIX TAG</td>
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<td>F 332</td>
<td>Continued From page 21 Do not crush enteric coated, sustained release...medications...</td>
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<td>Medical record review for Resident #1 documented an admission date of 12/21/09 with a re-admission date of 2/9/10 with diagnoses of Traumatic Fracture Hip, Chronic Airway Obstruction, Senile Dementia and Gastrostomy Status. Review of a physician's order dated 6/9/10 documented, &quot;...PREVACID 30 Mg [milligrams] 1 TAB PER PEG [Percutaneous Endoscopic Gastrostomy] TUBE EVERY DAY FOR REFLUX...&quot;</td>
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<td>Observations in Resident #1's room on 6/21/10 at 9:29 AM, revealed Nurse #1 crushed the Prevacid which was a Solutab-Delayed Release tablet. The crushing of the Prevacid resulted in medication error #1.</td>
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<td>2. Review of the facility's &quot;Administering Medications through an Enteral Tube&quot; policy documented, &quot;...4. Dilute medications...&quot;</td>
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<td>Medical record review for Resident #13 documented an admission date of 2/22/07 with a re-admission date of 1/16/10 with diagnoses of Late Effect Cerebral Vascular Disease, Hypertension and Hemiplegia. Review of a physician's order dated 6/11/10 documented, &quot;...POTASSIUM CHLORIDE [KCL] 20 MEQ [milliequivalents] / [per] 15ML [milliliter] GIVE 15CC [cubic centimeter] PER TUBE EVERY DAY. (DILUTE WITH WATER)...&quot;</td>
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<td>Observations in Resident #13's room on 6/21/10 at 11:08 AM, revealed Nurse #2 administered KCL 20mg to Resident #13 per PEG tube. Nurse #2 did not dilute the KCL with water as ordered.</td>
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Re-education on medication administration per an enteral tube to include the "DO NOT CRUSH LIST" will be completed on or before 7-22-10 by the SDC or designee for licensed nursing staff.

Nurses will complete a return demonstration competency for medication administration per an enteral tube with the SDC or designee on or before 7-22-10.

The Director of Nursing or designee will review medication administration per enteral tube competencies that have been completed weekly until all nurses have successfully demonstrated the competency.

The progress of completion of medication pass per enteral tube competencies will be brought to the monthly Quality Assurance and Assessment (QA&A) meeting and reviewed by the DNS or designee until all licensed nurses have completed competency.
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<th>PROVIDERS PLAN OF CORRECTION</th>
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<td>F 332</td>
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<td>The failure to dilute the KCL with water resulted in medication error #2.</td>
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<td>During an interview in the conference room on 6/23/10 at 9:45 AM, the Director of Nursing (DON) stated, &quot;They should dilute it [referring to KCL] it's kinda thick.&quot;</td>
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<td>3. Review of the facility's &quot;Administering Medications through an Enteral Tube&quot; policy documented, &quot;...4. ...flush the tube with room temperature or warm liquids...&quot;</td>
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<td>Medical record review for Resident #6 documented an admission date of 5/10/14 with diagnoses of Diabetic Cerebral Vascular Accident, Dysphagia Hypertension and Anemia. Review of a physician's order dated 5/14/10 documented, &quot;...Neurotin 200 mg per peg BID [two times a day]... Flush Peg tube 60cc H20 - [water] before + [and] after meds [medications].&quot;</td>
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<td>Observations in Resident #5's room on 6/21/10 at 4:18 PM, revealed Nurse #3 administered Neurotin 200mg to Resident #5. Nurse #3 did not flush the PEG tube with 60cc's of water before and after the medication. The failure to flush the PEG tube with 60cc's of water before and after the administration of medication resulted medication error #3.</td>
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<td>F 372</td>
<td>483.35(l)(3)</td>
<td>SS-D</td>
<td>DISPOSE GARBAGE &amp; REFUSE PROPERLY</td>
<td>F 372</td>
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<td>Maintenance Supervisor contacted the City of Ripley Street Department on June 21, 2010 regarding overflowing dumpsters.</td>
<td>7/22/10</td>
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<td>The facility must dispose of garbage and refuse properly.</td>
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<td>This was completed on June 21, 2010.</td>
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<td>SUMMARY STATEMENT OF DEFICIENCIES</td>
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<td>F372</td>
<td>Continued From page 23</td>
<td>Based on observation and interview, it was determined the facility failed to ensure the dumpster was covered and that garbage was properly contained in the dumpster on 1 of 3 (6/21/10) days of the annual survey. The findings included: Observations of the facility's dumpster on 6/21/10 at 9:30 AM, revealed the dumpster was uncovered and overfilled at least 4 feet above the doors. During an interview at the dumpster site on 6/21/10 at 9:30 AM, the Maintenance Supervisor stated, &quot;Yes, I need to call the city [in reference to the dumpster being overfilled].&quot; Observations of the facility's dumpster and the grounds around the dumpster on 6/21/10 at 10:30 AM, revealed the dumpster had been emptied but there was a strong odor and about a 3 foot area of thickly scattered used Q-tips were in front of the dumpster.</td>
<td>F372</td>
<td>Facility's waste disposal pick up schedule has been increased to 3 times a week. Maintenance Supervisor and/or Administrator will check dumpster area 3 times per week to ensure that area is clean and free of trash using the Maintenance Rounds Check-list. The Maintenance Supervisor and/or designee to report findings on a monthly basis to the Quality Assurance and Assessment Committee (QA&amp;A) for 2 months. The QA&amp;A Committee will determine the need for continued audit frequency at this time if 100% compliance has been met.</td>
<td>7/22/10</td>
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<tr>
<td>F425</td>
<td>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</td>
<td>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</td>
<td>F425</td>
<td>Resident #1 receiving medication at prescribed dosage.</td>
<td>7/22/10</td>
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<tr>
<td>SS=D</td>
<td>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet</td>
<td>Resident #8 receiving medication at prescribed dosage.</td>
<td>7/22/10</td>
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<td>Resident #9 receiving medication at prescribed dosage.</td>
<td>7/22/10</td>
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<td>F 425</td>
<td>Continued From page 24 the needs of each resident.</td>
<td>F 425</td>
<td>A Medication Administration Record to Medication Cart Audit will be completed by the Unit Manager or designee to ensure medications are available and administered per physician’s orders. This will be completed on or before 7/22/10.</td>
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The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation and interview, it was determined the facility failed to ensure medications were available for 3 of 15 (Residents #1, 8 and 9) sampled residents.

The findings included:

1. Medical record review for Resident #1 documented an admission date of 12/21/09 with a re-admission date of 2/6/10 with diagnoses of Traumatic Fracture Hip, Senile Dementia, Chronic Airway Obstruction and Gastrostomy Status. Review of a physician's order dated 6/9/10 documented, "...XANAX 0.5 MG [milligrams] 1 TAB [tablet] BY MOUTH THREE TIMES DAILY..." Review of the April 2010 Medication Administration Record (MAR) documented on 4/12/10 at 6:00 AM - Xanax not available.

2. Medical record review for Resident #8 documented an admission date of 5/31/07 with a re-admission date of 10/3/09 with diagnoses of Late Effect Cerebral Vascular Disease, Alzheimer's Disease, Osteoporosis and Depressive Disorder. Review of a physician's order dated 4/10 and updated 5/15/10
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 425</td>
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<td>Continued From page 25</td>
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</table>

- "...ARICEPT 10 mg AT HS [hour of sleep], NEURONTIN 100 MG AT HS, LEVAMISOLE 100 MG AT HS, REMORON 150 MG AT HS...CRANBERRY PLUS 2 TWICE DAILY..."
- Review of the April 2010 MAR documented 4/22/10 - Neurontin and Lexapro not available has been re-ordered and 4/27/10 - Cranberry capsules not available.
- Review of the May 2010 MAR documented on 5/20/10 at 8:00 PM - Remeron not available and 5/21/10 at 8:00 PM - Aricept, Neurontin, Lexapro and Remeron not available.
- Observations on 6/22/10 at 4:45 PM, during the medication administration pass on Resident #8 revealed the Cranberry capsules were not available.

3. Medical record review: Resident #8 documented an admission date of 9/24/09 with diagnosis of Osteoporosis, Depressive Disorder and Chronic Airway Obstruction. Review of a physician's order dated 4/10/10 and updated on 6/1/10 documented "...REQUIP TAKE 1 TAB BY MOUTH [PO] AT BEDTIME...CLINORIL 1 TAB BY MOUTH TWICE DAILY...ATIVAN 0.5 MG 1 PO Q [every] AM..." Review of the April 2010 MAR documented 4/5/10 at 8:00 PM - Requip not available; 4/16/10 at 5:00 PM - Clinoril not available and 4/19/10 at 9:00 AM and 5:00 PM - Clinoril not available. Review of the May 2010 MAR documented 5/9/10 at 9:00 AM - Ativan not available.

During an interview in the conference room on 6/23/10 at 9:35 AM, the Director of Nursing confirmed that "the drugs should be ordered 7 to 8 days before they run out... and that back up

The QA&A Committee will determine the need for continued audit frequency at this time if 100% compliance has been met.
<table>
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<tr>
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<tr>
<td>F 425</td>
<td>Continued From page 26 Pharmacy is available 24-7 [24 hours a day 7 days a week].&quot; 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</td>
<td>F 425</td>
<td>All medication will be stored properly and medication carts will be locked when left unattended or out of sight of the nurse administering medications.</td>
</tr>
<tr>
<td>F 431 S=6</td>
<td>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 is 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 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.</td>
<td>7/22/10</td>
<td>All expired medication has been disposed of. Audits were completed by the Unit Manager on each unit to ensure that medications were stored and locked properly. The Unit Manager has checked med carts and med rooms for expired medication and has disposed of all. Nursing staff will be re-educated by the SDC or designee on or before July 22, 2010 on adhering to the policy on storage of medication and disposing of and reordering of expired medications. The Director of Nursing and Unit Managers will Audit med carts at least twice a week for proper storage and medications that have expired.</td>
</tr>
</tbody>
</table>
Continued from page 27

This "REQUIREMENT" is not met as evidenced by:

Based on policy review, observations and interview, it was determined the facility failed to ensure 2 of 6 (400 hall medication cart and 500-512 hall medication cart) medication storage areas were locked when unattended and medications were not stored past their expiration date in 4 of 6 (500-512 medication cart, 600 hall medication room, 400 hall medication cart and 100 hall medication room) medication storage areas.

The findings included:

1. Review of the facility's "Storage of Medications" policy documented, "The facility shall store all drugs and biologicals in a safe, secure, and orderly manner... Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others."

   a. Observations on the 500 hall on 6/21/10 at 4:31 PM and 4:38 PM, revealed the 500-512 hall medication cart was left unattended, unlocked, and out of view of the nurse.

   b. Observations on the 400 hall on 6/22/10 at 4:25 PM, revealed the 400 hall medication cart was left unattended, unlocked, and out of view of the nurse.

During an interview in the conference room on 6/23/10 at 9:45 AM, the Director of Nursing stated, "It (referring to medication carts) should be..."
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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</thead>
<tbody>
<tr>
<td>F 431</td>
<td></td>
<td>Continued From page 28 2. Review of the facility's &quot;Storage of Medications&quot; policy documented, &quot;...The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed...&quot;</td>
<td>F 431</td>
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<tr>
<td></td>
<td></td>
<td>a. Observations of the 500-512 medication cart on 6/23/10 at 9:15 AM, revealed the medication cart contained Hydrocodone 7.5/500 milligrams (mg) tablets stored past the expiration date of 3/30/10 and Hydrocodone 7.5/500 mg tablets stored past the expiration date of 6/11/10.</td>
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<td>b. Observations in the 500 hall medication room on 6/23/10 at 10:10 AM, revealed Diocto Liquid and Normal Saline stored past the expiration date of 5/10.</td>
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<td>c. Observations of the 400 hall medication cart on 6/23/10 at 10:40 AM, revealed Lorazepam 1 mg tablets stored past the expiration date of 12/29/09 and Lorazepam 0.5 mg tablets stored past the expiration dates of 12/29/09, 1/31/10 and 4/23/10.</td>
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<td>d. Observations of the 100 hall medication room on 6/23/10 at 11:00 AM, revealed Diocto Liquid stored past the expiration date of 5/10.</td>
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<tr>
<td>F 441</td>
<td>SS=E</td>
<td>483.85 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.</td>
<td>F 441</td>
<td></td>
<td>Nurse #2 was re-educated on hand hygiene; cleaning the top of the insulin vial before drawing up insulin; cleaning the glucometer with Sani-clOTH wipes before and after use for resident #3.</td>
<td>7/22/10</td>
</tr>
</tbody>
</table>
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:**
445492

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING

B. WING

**(X3) DATE SURVEY COMPLETED:** 05/23/2010

**NAME OF PROVIDER OR SUPPLIER:**
RIPLEY HEALTHCARE AND REHAB CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
118 HALLEBURTON DRIVE
RIPLEY, TN 38063

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**F 441**

**Continued From page 29**

(a) Infection Control Program

The facility must establish an Infection Control Program under which it:

1. Investigates, controls, and prevents infections in the facility;
2. Decides what procedures, such as isolation, should be applied to an individual resident; and
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.

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**F 441**

Nurse #3 was re-educated on hand hygiene and cleaning the stethoscope and blood pressure cuff after each use per manufactures recommendations.

C.N.A. #2 was re-educated on hand hygiene during tray delivery.

Nurse #6 was re-educated on placing eye drops on over bed table using a barrier for Random Resident #2.

Residents were monitored for signs and symptoms of infection no one was affected by practice.

All nursing staff will be re-educated by the SDC or designee on or before July 22, 2010 on hand hygiene; cleaning equipment between resident uses; medication administration and wound cleansing.
Continued from page 30

direct resident contact. Four (4) of 11 nurses (Nurses #2, 3, 4, and 6) failed to clean/disinfect resident care equipment or medication containers and failed to cleanse a wound in a manner to prevent the spread of potential infections.

The findings included:

1. Review of the facility's "Handwashing/Hand Hygiene" policy documented, "This facility considers handwashing/hand hygiene as the primary means to prevent the spread of infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections... Employees must wash their hands for ten (10) of fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water... Dry hands thoroughly with paper towels and turn off faucets with a clean, dry paper towel."

   a. Observations on the 500 hall on 6/21/10 at 4:09 PM, 4:18 PM and 4:31 PM, Nurse #3 washed her hands and turned the faucet off with her bare hand.

   b. Observations in room 603 on 6/21/10 at 6:20 PM. CNA #2 touched a resident's legs, did not wash her hands or use hand sanitizer and then continued to deliver meal trays.

   c. Observations on the 100 hall on 6/21/10 at 6:25 PM, revealed Nurse #2 washed her hands without using soap.

During an interview in the conference room on 6/23/10 at 9:45 AM, the Director of Nursing (DON) was about handwashing technique. The DON stated, "They [staff] would have to use..."
**F 441** Continued From page 31

**soap.**

2. Review of the facility's "Cleaning Stethoscope" policy documented, "The purpose of this procedure is to prevent cross contamination when using a stethoscope between residents and/or when a stethoscope is used by multiple staff members... Using firm pressure, clean stethoscope ear pieces, tubing, diaphragm and bell in a circular motion... Return the stethoscope to its designated storage area..."

Observations on the 500 hall on 6/21/10 at 4:09 PM and 4:18 PM, revealed Nurse #3 did not clean the stethoscope before of after using it.

3. Review of the facility's "Decontaminating and Labeling Equipment" policy documented, "...Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturer's instructions..."

Observations on the 100 hall on 6/21/10 at 11:50 AM, revealed Nurse #2 cleaned the glucometer with an alcohol swab before and after an accucheck on Resident #3. Nurse #2 did not use the Sani-Cloth Bleach wipes.

Observations on the 500 hall on 6/21/10 at 4:09 PM and 4:18 PM, revealed Nurse #3 did not clean the blood pressure cuff before or after using it.

During an interview in the conference room on 6/23/10 at 9:45 AM, the Director of Nursing (DON) stated, "They have the wipes, the Sani-pads with bleach and should be using them."

4. Observations on the 100 Hall on 6/22/10 at...
Continued From page 32:

12:20 PM, revealed Nurse #2 did not clean the top of the insulin vial before drawing up insulin.

5. Observations in Random Resident #2's room 6/22/10 at 4:25 PM, revealed Nurse #8 placed the top of the Systane (eye drops) downward on the over bed table without a barrier.

6. Review of the facility's "Dressings, Dry/Clean" policy documented, "If using gauze, use a clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated area (usually, from the center outward)."

Observations during a dressing change in Resident #1's room on 6/23/10 at 10:35 AM, revealed Nurse #4 performed wound care for Resident #1's coccyx stage 2 decubitus ulcer. Nurse #4 patted each area of the wound with the same gauze moistened with wound cleanser and patted each area of the wound with the same dry gauze.