| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLA. IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION  
A. BUILDING  
B. WING  
| (X3) DATE SURVEY COMPLETED |  |
| NAME OF PROVIDER OR SUPPLIER | COUNTRYSIDE HEALTHCARE AND REHABILITATION | STREET ADDRESS, CITY, STATE, ZIP CODE  
3001 BUFFALO ROAD  
LAWRENCEBURG, TN 38464 |
| () ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSD IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | () COMPLETION DATE |
| F 157 | 483.10(b)(11) NOTIFY OF CHANGES  
(INJURY/DECLINE/ROOM, ETC) | F 157 | 483.10(b)(11) Notify of Changes  
(Injury/Decline/Room, etc), ID Prefix Tag F 157 |
| SS=O | A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). |
| The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. |
| The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. |
| 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 staff notified the physician of an |

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE  
SS=O  
F 157  
F 157  

TITLE  
Administrator  

(XX) DATE  
11/16/10  

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 disclosable 90 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 disclosable 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.
F 157 Continued From page 1 emergency transfer for 2 of 22 (Residents #21 and 22) sampled residents.

The findings included:

1. Review of the facility's "Making an Emergency Transfer or Discharge" policy documented, "...Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: a. Notify the resident's Attending Physician..."

2. Medical record review for Resident #21 documented an admission date of 5/18/04 with a readmission date of 8/23/10 with diagnoses of Congestive Heart Failure, Pneumonia, Urinary Tract Infection, Dementia, Osteoporosis, Venous Thrombosis, Depression, Muscle Weakness, Abnormal Gait, Muscle Atrophy and Hypertension. Review of a Nurse's Note dated 10/5/10 documented, "...called to Rm [room] per staff, upon entry resident [resident] in bed... unresponsive to verbal + [and] tactile stimuli... unable to obtain V/S [vital signs]... CPR [cardiopulmonary resuscitation] initiated... named emergency management service leaving facility... resident-destination [named hospital] CPR still in progress." There was no documentation in the medical record that the physician had been notified of Resident #21's emergency transfer.

During an interview in the quiet room on 11/3/10 at 10:30 AM, the Director of Nursing (DON) confirmed there was no documentation the physician was notified. The DON stated, "It [physician notification] is not documented, I know it should be."
F 157 Continued From page 2
3. Medical record review for Resident #22 documented an admission date of 10/17/08 and a readmission date of 6/14/09 with diagnoses of Dementia, Depressive Psychosis, Anxiety, Hypertension, Congestive Heart Failure and Arthritis. Review of the Nurse's Notes dated 6/14/10 documented, "...transferred pt [patient] to [named hospital] ER [Emergency Room]..." There was no documentation in the medical record that the physician was notified of Resident #22's emergency transfer.

During an interview in the quiet room on 11/2/10 at 5:06 PM, the DON was asked if the physician was contacted when Resident #22 was sent to the ER. The DON reviewed Resident #22's medical record and stated, "...I don't see in the record that the doctor was notified."

F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
Based on policy review and observations, it was determined the facility failed to ensure 1 of 7 (Nurse #4) medication nurses and 1 of 3 Certified Nursing Assistant (CNA #3) maintained residents' dignity and respect by entering residents' rooms without knocking or gaining permission prior to entering the residents' room.

The findings included:

REQUIREMENT:
The facility will maintain an environment that promotes each resident's dignity and respect in full recognition of his or her individuality.

CORRECTIVE ACTION:
1. The DON re-trained the facility staff on maintaining resident privacy and dignity on 11-10-10. This interview will be repeated again on 11-19-10 and 12-03-10.
2. All residents have the potential to be affected by dignity and respect of individuality. To protect other residents and prevent a recurrence, the DON or designee will conduct random privacy audits 3 times per week for 4 weeks to ensure the privacy and dignity of residents are observed by staff.
3. The DON will monitor the results of audit findings and report findings to the Q&A Committee for the months of November and December 2010.

COMPLETION DATE: 11-10-10
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<th>ID (Prefix) Tag</th>
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| **F 241**      | Continued From page 3  
   1. Review of the facility's "Quality of Life - Dignity" policy documented, "...6. Resident's private space and property shall be respected at all times, a. Staff will knock and request permission before entering resident's rooms..."  
   2. Observations during medication administration on 11/2/10 at 9:20 AM, Nurse #4 entered room 108 without knocking on the door or gaining permission to enter.  
   Observations during medication administration on 11/2/10 at 5:50 PM, Nurse #4 entered room 120 without knocking on the door or gaining permission to enter.  
   3. Observations during dining on 11/2/10 at 6:00 PM, CNA #3 entered room 204 without knocking on the door or gaining permission to enter. |
| **F 309**      | 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:  
   Based on medical record review, observation and interview, it was determined the facility failed to follow physician's orders for no caffeine for 1 of 22 (Resident #14) sampled residents.  
   The findings included: |
| **F 241**      | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING, ID Prefix Tag F 309  
   REQUIREMENT:  
   The facility will ensure that physician orders for no caffeine are followed as written.  
   CORRECTIVE ACTION:  
   1. The physician was notified of the resident being served tea within 24 hours of the scheduled test. The physician ordered the test to be given as scheduled.  
   2. All residents with a pre lab, no caffeine order have the potential to be affected. To prevent re-occurrence, the Dietary Manager reviewed all dietary lab orders with no negative findings and communicated current dietary restrictions to the dietary staff on 11-04-10.  
   3. On 11-05-10 the Dietary Manager in-served the dietary staff on following dietary restrictions during meal preparation and tray service.  
   4. The Dietary Manager will monitor to ensure that dietary orders are followed through daily monitoring of the tray preparation for 4 weeks and report findings to the Q&A committee for months of November and December 2011.  
   COMPLETION DATE: 11-10-10 |
F 309

Medical record review for Resident #14 documented an admission date of 6/11/07 and readmission date of 11/29/09 with diagnoses of Chest Pain, Urinary Tract Infection, Neuropathy in Diabetes, Anxiety, Agoraphobia, Hypertension, Esophageal Reflux, Hypothyroidism and Heart Disease. Review of a physician's order dated 10/26/10 documented, "Send for Lexiscan Thallum Test 11-3-10... No caffeine for 24 [hours] before test..."

Observation in Resident #14’s room on 11/2/10 at 1:05 PM, revealed Resident #14 was served regular tea.

During an interview in the hall outside Resident #14's room on 11/2/10 at 1:05 PM, the Licensed Practical Nurse #6 confirmed the tea was not caffeine free.

F 322

483.25(g)(2) NG Treatment/Services - Restore Eating Skills

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 nasal-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, observation and interview, it was determined Nurse #4 failed to administer medications appropriate by failing to check the placement of
**F 322** Continued From page 5

The Percutaneous Endoscopy Gastrostomy (PEG) Tube prior to administering medications to 1 of 1 (Resident #13) sampled residents with a PEG tube.

The findings included:

- Review of the facility's "Medication Administration via Enteral Tubes" policy documented, "...8) Check for proper tube placement..."

- Medical record review for Resident #13 documented an admission date of 1/9/06 and readmission date of 6/13/09 with diagnoses of Paralysis Agitation, Senile Dementia, Heart Block, Hypertension and Gastrostomy. Review of the physician's orders dated 9/10/10 documented: "...Consume 200mg [milligrams] per tube q [every] 3 hrs [hours], MAY CRUSH FOR ADMINISTRATION... Carbipoda/Levodopa 10/100 per tube Q 3 hrs...Check placement and residual q shift..."

- Observations in Resident #13's room on 11/2/10 at 9:25 AM, Nurse #4 connected a syringe with dissolved Comtan and Carbipoda/Levodopa and pushed the medication into the PEG tube. Nurse #4 did not check Resident #13's tube placement prior to administering medications to Resident #13.

- During an interview in Resident #13 room on 11/2/10 at 9:30 AM, Nurse #4 was asked if she had checked the placement of Resident #13's PEG tube. Nurse #4 stated, "No ma'am."

**F 332 483.25(m)(1) FREE OF MEDICATION ERROR**, **SS=0 RATES OF 5% OR MORE**

The facility must ensure that it is free of...
Continued From page 6 medication error rates of five percent or greater.

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 administer medication with a medication error rate of less than 5 percent (%) when 2 of 7 nurses (Nurses #4 and #5) made three (3) medication errors out of 47 opportunities for error. These errors resulted in a medication error rate of 6.38%.

The findings included:

1. Medical Record review for Random Resident (RR) #2 documented an admission date of 4/19/10 with diagnoses of Paraplegia, Anxiety, Depressive Disorder, General Ostearthrosis and Benign Hypertension. Review of the physician's orders dated 9/2/10 documented, "...Artificial Tears two drops to both eyes BID [twice a day]..."

Observations in RR #2's room on 11/1/10 at 4:00 PM, Nurse #5 administered three drops of Gentical ophthalmic eye drops in RR #2's left eye. The failure to administer the correct Artificial Tears ophthalmic drops as ordered resulted in medication error #1.

During an interview at RR #2's bedside on 11/1/10 at 4:05 PM, Nurse #5 stated, "I had it [Gentical ophthalmic eye drops] in my pocket, it was the roommate's eye drops..."

F 332

F 332 483.15(n)(1) Free of Medication Errors of 5% or more, ID Prefix F 332

REQUIREMENT:
The facility will ensure that medications are administered with a medication error rate of less than 5%.

CORRECTIVE ACTION:
1.a. Resident #2's physician was notified of the medication error regarding eye drops with no new orders.
1.b. Resident #13's Enteral tube was checked for proper placement on 11-10-10 and was placed properly.
1.c. Resident #1's physician was notified of the multi-vitamin medication error with no new orders.
2. All resident receiving medications have the potential to be affected. To prevent re-occurrence, the DON in-services licensed nurses on 11-10-10 regarding proper procedures for medication passes. This service will be repeated again on 11-19-10.
3. The DON or designee will conduct audits of medication passes 5 times a week for 4 weeks to ensure compliance.
4. Audit results will be monitored by the DON and presented to the QA&A committee for the months of November and December 2010.

COMPLETION DATE: 11-10-10
F 332 Continued From page 7

Medical record review for Resident #13 documented an admission date of 1/8/05 and readmission date of 6/13/09 with diagnoses of Paralysis Agitans, Senile Dementia, Heart Block, Hypertension and Gastrostomy. Review of the physician’s orders dated 9/10/10 documented, "...Continue 200mg [milligrams] per tube q [every] 3hrs [hours], MAY CRUSH FOR ADMINISTRATION... Carbidopa/Levodopa 10/100 per tube Q 3 hrs... Flush peg tube with 30cc [cubic centimeters] H2O [water] before and after meds, Flush peg tube with 210 cc water Q 4 hours..."

Observations in Resident #13’s room on 11/2/10 at 9:26 AM, revealed Nurse #4 connected a syringe to the PEG tube with Carbidopa and Levodopa dissolved in water, and pushed the medication into the PEG tube. Nurse #4 did not flush the PEG tube prior to administration of medication which resulted in medication error #2.

3. Medical Record review for RR #1 documented an admission date of 3/19/10 with diagnoses of Open Wound Chest, Bipolar Disorder and Diabetes Mellitus. Review of the physician’s orders dated 9/8/10 documented "...MVI [Multi-Vitamin] with minerals one po [by mouth] Q [every] day..."

Observations in RR #1’s room on 11/2/10 at 10:10 AM, Nurse #4 administered MVI one tablet
**NAME OF PROVIDER OR SUPPLIER**
Countryside Healthcare and Rehabilitation

**STREET ADDRESS, CITY, STATE, ZIP CODE**
3051 Buffalo Road
Lawrenceburg, TN 38464

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<td>Continued from page 6 by mouth. The failure to administer MVI with minerals resulted in medication error #3. During an interview at the east wing nurse's station on 11/2/10 at 10:20 AM, Nurse #4 reviewed RR #1's physician's order and stated, &quot;I gave MVI without minerals....&quot;</td>
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