N 669 1200-8-6-06(4)(c)4. Basic Services

(4) Nursing Services.

(c) The Director of Nursing shall have the following responsibilities:

4. Notify the resident’s physician when medically indicated.

This Rule is not met as evidenced by:
Type C Pending Penalty #4

Tennessee Code Annotated 68-11-804(c)4: Nursing homes shall notify the patient’s physician of the condition of a patient, when it is medically indicated.

Based on policy review, medical record review and interview, it was determined the facility failed to ensure staff notified the physician of a seizure for 1 of 23 (Resident #19) sampled residents.

The findings included:

Review of the facility’s untitled policy concerning physician notification documented: "(A) A facility must immediately inform the resident; consult with the resident’s physician... when there is... (B) A significant change in the resident's physical, mental, or psychosocial status..."

Medical record review for Resident #19 documented an admission date of 1/2/09 with diagnoses of Seizure Disorder, Chronic Obstructive Pulmonary Disease, Hypothyroidism, Sleep Apnea and Affective Personality Disorder. Review of the nurse’s notes dated 10/28/10 documented, "...515p [PM] Walked in Residents

REQUIREMENT:

The facility will notify the patient’s physician of the condition of a patient, when it is medically indicated.

CORRECTIVE ACTION:

1. On 11-08-10 the DON notified the physician for resident #19 regarding seizure activity that occurred 10-28-10.

2. On 11-10-10 the Risk Management Nurse conducted chart audits to ensure that physicians were notified regarding significant change in resident’s status.

3. On 11-12-10 The DON conducted in-service with licensed nurses regarding notification of physician regarding significant change in resident’s status.

4. The DON, ADON and Risk Management will conduct random chart audits monthly to ensure that physicians are notified regarding significant change in resident’s status and will report findings to QA & A Committee quarterly.

Completion Date: 11-28-2010
Continued From page 1

[Category 19] room to find him lying in bed supine having a seizure. His eyes were rolled back, arms swaying and legs kicking in air..." There was no documentation in the medical record that the physician had been notified of Resident #19 having a seizure on 10/28/10.

During an interview at the 100/200 hall nurse’s station on 11/8/10 at 4:00 PM, the Director of Nursing (DON) was asked if the physician was notified when Resident #19 had a seizure on 10/28/10. After reviewing the medical record the DON stated, "I don't see that the doctor was notified. I wasn't called. They [nurses] are supposed to call the doctor of any change..."

N 728
1200-8-6.06(6)(b) Basic Services

(6) Pharmaceutical Services.

(b) Such cabinets or drug rooms shall be kept securely locked when not in use, and the key must be in the possession of the supervising nurse or other authorized persons.

This Rule is not met as evidenced by:
Type C Pending Penalty #7

Tennessee Code Annotated 68-11-804(c)7: Such cabinets or drug rooms shall be kept securely locked when not in use, and the key must be in the possession of the supervising nurse or other authorized person on duty.

Based on policy review, observation and interview, it was determined the facility failed to ensure medications were secured in 1 of 6 (300 hall medication cart) medication storage areas.

1. On 11-11-10 the DON conducted in-service with Nurse #1 on 300 hall regarding locking of the medication cart when cart is left unattended. The DON observed Nurse #1 to ensure that the medication cart was locked when left unattended.
**MCNAIRY COUNTY HEALTH CARE CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
835 EAST POPLAR AVENUE
SELMER, TN 38375

**DATE SURVEY COMPLETED**
11/09/2010

<table>
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<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETE DATE</th>
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</thead>
</table>
| N728 | Continued From page 2 | The findings included:  
Review of the facility's "PROPER ADMINISTRATION AND DOCUMENTATION OF UNIT DOSE MEDICATION" policy documented, "...10. Never leave the med [medication] cart unattended when it is unlocked, and never leave meds sitting on top of med cart unattended..."  
Observations on the 300 hall on 11/6/10 at 5:25 PM, Nurse #1 left the 300 hall medication cart unlocked, unattended and out of her view.  
During an interview on the 300 hall at 5:25 PM, Nurse #1 confirmed she left the medication cart unlocked. | N728 | | 2. On 11-11-10 the DON, ADON and Risk Management Nurse conducted random medication pass audits to ensure that licensed nurses were locking medication carts when carts were left unattended.  
3. On 11-12-10 the DON conducted in-service with licensed nurses regarding locking of medication carts when carts are left unattended.  
4. The DON, ADON, and Risk Management Nurse will conduct monthly medication pass audits of licensed nurses to ensure that medication carts are locked when carts are left unattended and will report findings to the QA & A Committee quarterly. | 11-28-2010 |

Completion Date: 11-28-2010