TRICOUNTY HEALTHCARE CENTER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 445397

(X2) MULTIPLE CONSTRUCTION
A. BUILDING __________________
B. WING __________________

(X3) DATE SURVEY COMPLETED 12/01/2010

STREET ADDRESS, CITY, STATE, ZIP CODE
409 PARK AVENUE
ADAMSVILLE, TN 38310

NAME OF PROVIDER OR SUPPLIER

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

ID PREFIX TAG DESCRIPTION

F 280 SS-D 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review, and interviews, it was determined the facility failed to revise the comprehensive care plan for care of emergency bleeding for 2 of 22 (Resident #18 and 19) sampled residents.

The findings included:

1. Review of the facility's "Dialysis, Hemodialysis" policy documented, "...Check graft site for bleeding upon return post-dialysis and per MD [Medical Doctor] orders. If bleeding occurs, apply direct pressure until controlled. Notify MD and...

Laboratory Director's or Provider/Supplier Representative's Signature

Title

Mark Date 12/15/10

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.

This page was faxed 12/11/10

If continuation sheet Page 1 of 22
<table>
<thead>
<tr>
<th>(K4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LIC IDENTIFYING INFORMATION)</th>
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| F 280             | Continued From page 1 DON [Director of Nursing] if bleeding lasts longer than 30 minutes or is severe initiate EMS [Emergency Management Service] system." 2. Medical record review for Resident #18 documented an admission date 4/12/10 with diagnoses of Hypothyroidism, Neurosyphilis, Anemia, Constipation, Congestive Heart Failure, Hypertension, Alzheimer's, Spina Bifida, and Chronic Kidney Disease. Review of the care plan dated 1/26/10 documented "...Hemodialysis as ordered. Assess site,... q [every] d [day] for s/s [signs and symptoms].inf.[Infection] or bleeding... assess for thrill/bruit q shift." The care plan did not address measures to be put in place to stop emergency bleeding. During an interview at the side 3 nurses' station on 12/1/10 at 1:00 PM, Nurse #9 stated, "[Care plan] says to check for it [emergency bleeding] but doesn't really say what to do for it." 3. Medical record review for Resident #19 documented an admission date of 2/11/10 with a readmission date of 9/11/10 with diagnoses of End Stage Renal Disease, Hyperlipidemia, Epilepsy, Diabetes, Hypertension, Anemia, Anxiety, History of Cerebrovascular Accident with Right Hemiparesis, Thrombocytopenia, and Expressive Aphasia. Review of the care plan dated 2/23/10 documented "...Check shunt or port site for s/s of infections, pain or bleeding daily and PRN [as needed]..." The care plan did not address measures to be put in place to stop emergency bleeding. During an interview at the side 1 nurses' station on 12/1/10 at 1:52 PM, the DON stated, "If [care plan] should have interventions for a bleed but...
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**483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PERS 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, and interviews, it was determined the facility failed to follow interventions on the care plan for floor mats and a pressure relief mattress for 1 of 22 (Residents #5) sampled residents.

- The findings included:

  - Medical record review for Resident #5 documented an admission date of 5/15/06 with diagnoses of Alzheimer’s Disease, Muscle Disuse Atrophy, Depressive Disorder, Pneumonia, Thrombocytopenia, and Dementia. Review of the comprehensive care plan dated 1/27/10 documented, "...pressure relief mattress for comfort and prevention..." and dated 2/25/10 documented, "...low bed with mats in place..."

  - Observations in Resident’s #5’s room on 11/29/10 at 4:00 PM and on 11/30/10 at 8:30 AM, 12:05 PM and 2:20 PM, revealed there were no floor mats and a pressure relief mattress in place for Resident #5.

  - During an interview in Resident #5's room on 1/30/10 at 2:40 PM, Nurse #7 verified there were no floor mats or a pressure relief mattress.
| ID | F 282 | Continued From page 3 present. During an interview at side 1 nurses' station on 11/30/10 at 2:45 PM, the Director of Nursing confirmed that floor mats and pressure relief mattresses were on the care plan but were not implemented for Resident #5. |
| ID | 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 and interviews, it was determined the facility failed to follow physician orders to recheck blood sugars (BS) for 2 of 4 (Residents #17 and 19) sampled residents. The findings included: 1. Medical record review for Resident #17 documented an admission date of 5/2/05 with a readmission date of 2/10/10 with diagnoses of Diabetes Mellitus, Dementia with Behavior Disturbances and Morbid Obesity. Review of a physician's order dated 8/17/10 documented, "...NOVOLIN R [regular 100U [units] / [per] ML [milliliter] VIAL INJECT SQ [subcutaneous] PER SCALE ... ABOVE 300 = [amount of insulin to be administered] AND CALL MD [Medical Doctor] IF NO RESULTS..." Review of the July 2010... |
Continued From page 4

F 309

diabetic record for Resident #17 revealed the following BS’s above 300 that were not rechecked to determine the results of the insulin administered:

a. 7/10/10-4:30 PM, BS-354.
b. 7/15/10-4:30 PM, BS-314.
c. 7/15/10-6:00 PM, BS-338.
d. 7/17/10-11:30 AM, BS-321.
e. 7/17/10-6:00 PM, BS-314.
f. 7/21/10-11:30 AM, BS-311.
g. 7/21/10-8:00 PM, BS-397.
h. 7/22/10-11:30 AM, BS-307.
i. 7/23/10-4:30 PM, BS-430.
j. 7/23/10-8:00 PM, BS-381.
k. 7/25/10-8:00 PM, BS-328.
l. 7/28/10-4:30 PM, BS-310.
m. 7/29/10-7:30 AM, BS-305.
n. 7/29/10-8:00 PM, BS-380.
o. 7/30/10-8:00 PM, BS-318.

During an interview in the conference room on 12/1/10 at 10:45 AM, Nurse #8 stated, "They need to recheck it [BS] to see if the BS has gone down, that's the only way to know the results. Usually recheck it in 45 minutes to an hour unless the doctor has a specific order."

**F 309** Continued From page 5

Review of the October 2010 medication administration record (MAR) for Resident #19 documented the following BS results:
- a. 10/4/10 8 PM BS 441.
- b. 10/15/10 5:30 PM BS 433.

The facility was unable to provide documentation of rechecks in 2 hrs of a BS over 400.

Further medical record review revealed a physician's telephone order dated 10/4/10 documented, ". . . Give Nov R 15 u now Recheck in 2 hrs [hours] for BS 442 . . ." Review of the daily skilled nurses notes documented, ". . . 10/4/10 12:00 AM Rechecked blood sugar c result of 442. Called MD was ordered to give 16 units Nov R, now then recheck in 2 hrs . . ." There was no documentation the BS was rechecked in 2 hours after administering the insulin.

During an interview at the side 1 nurse's station Nurse #8 reviewed Resident #19's MAR and the nurses notes and stated, ". . . She [medication nurse] didn't recheck [BS] in 2 hrs . . ."

**F 332**

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 interviews, it was determined the facility failed to ensure 3 of 6 (Nurses #3, 5 and 6) nurses administered medications with a medication error rate of less than 5 percent (%).
### SUMMARY STATEMENT OF DEFICIENCIES

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<td>F 332</td>
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<td>2. Residents with eye drops, inhalers and insulin have the potential to be affected by this situation. An Beginning 11/30/2010 Director of Nursing did medication audits including audit of residents with eye drops, inhalers and insulin was completed on 12/7/2010 by the Director of Nursing and/or Nursing Supervisor.</td>
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### Observations

**Observations in RR #1’s room on 11/29/10 at 11:45 AM, revealed Nurse #3 delivered two puffs of a Combivent inhaler to RR #1. Nurse #3 did not pause between the puffs. Failure to pause at least one minute between the puffs resulted in medication error #1.**

**Observations in Resident #6’s room on 11/30/10 at 6:25 AM, revealed Nurse #6 administered one...**
### Summary Statement of Deficiencies

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| F 332 | Continued from page 7. Failure to administer two eye drops into each eye resulted in medication error #2. During an interview on side three on 11/30/10 at 8:20 AM, Nurse #6 stated, "You're right I should have given two drops and I only gave one." 3. Review of the facility's "Insulin Administration" policy documented, "...8. Check the order for the amount of insulin..." Medical record review for Resident #16 documented an admission date of 3/19/05 with diagnoses of 4/11/10 with diagnoses of Chest Pain, Diabetes Mellitus, Hypertension, and Glaucoma. Review of a physician's order dated 11/30/10 documented, "Bedside glucose Sliding Scale Clarification: 0- to 150- [amount of insulin to be administered] 0 units." Observations in Resident #16's room on 11/30/10 at 7:15 AM, Nurse #6 performed a fingerstick blood sugar (FSBS) on Resident #16's with results of 120. Nurse #6 administered Novolin R 2 units to Resident #16. The administration of 2 units of Novolin R insulin resulted in medication error #3. During an interview on side 3 on 11/30/10 at 11:55 AM, the Director of Nursing stated, "It [referring to insulin dosage] was a transcription error. We did incident report, notified doctor and checked all other orders, didn't find any other problems." 4. Review of the facility's "Insulin Administration" policy documented, "...6. Gently roll the insulin vial between palm of both hands to resuspend the
### Continued From page 6

Insulin...

**a.** Medical record review for Resident #15 documented an admission date of 9/10/09 with diagnoses of Diabetes Mellitus, Dementia and Chronic Kidney Disease. Review of a physician’s order dated 11/16/09 documented, "Order clarification: (1) Novolin 70/30 q [every] A.M. @ [at] 6:45 AM (2) Bedside Glucose time change to 545 AM, 1130 AM, 445 PM, 600 PM c [with] Novolog 6 units SQ [subcutaneous] as ordered due to mealtime changes to begin 11/17/10." Review of a physician's order dated 11/30/10 documented, "Order clarification Novolin 70/30 25U [units] sq @ 6:45 am."

Observations in Resident #15's room on 11/30/10 at 6:45 AM, revealed Nurse #5 administered Novolin 70/30 25 units to Resident #15. Nurse #5 did not roll the insulin vial to resuspend the insulin prior to drawing up the insulin. Failure to roll the insulin vial resulted in medication error #4.

**b.** Medical record review for Resident #10 documented an admission date of 11/28/07 with a readmission date of 4/28/09 with diagnoses of Diabetes Mellitus, Gastroparesis, and Hypertension. Review of a physician’s order dated 11/1/10 documented, "...NOVOLIN 70/30 INJECT 165 UNITS SQ 2 TIMES DAILY AT 7:45 AM & [and] 4:45 PM..."

Observations in Resident #10's room on 11/30/10 at 7:20 AM, Nurse #6 administered Novolin 70/30 165 units to Resident #10. Nurse #6 did not roll the vial of insulin prior to drawing up the insulin to resuspend the insulin. Failure to roll the vial of insulin resulted in medication error #5.

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<td>F 334</td>
<td>483.25n INFLUENZA AND PNEUMOCOCCAL</td>
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IMMUNIZATIONS

The facility must develop policies and procedures that ensure that—
(i) Before offering the influenza immunization, each resident, or the resident’s legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident’s legal representative has the opportunity to refuse immunization; and
(iv) The resident’s medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or the resident’s legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that—
(i) Before offering the pneumococcal immunization, each resident, or the resident’s legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(x1) PROVIDER/SUPPLIER/LIA IDENTIFICATION NUMBERS:

445397

(x2) MULTIPLE CONSTRUCTION

A. BUILDING

WING

(x3) DATE SURVEY COMPLETED

12/01/2010

NAME OF PROVIDER OR SUPPLIER

TRICOUNTY HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

409 PARK AVENUE

ADAMSVILLE, TN 38310

F 334 Continued From page 10

already been immunized;

(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:

(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and

(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review, and interview, it was determined the facility failed to provide the influenza vaccine for 1 of 22 (Resident #7) sampled residents.

The findings included:

Review of the facility's "Vaccination of Residents" policy documented, "...Influenza Vaccination... all residents will be offered an influenza vaccine beginning in October of each year, unless
F 334  Continued From page 11
medically contraindicated or the resident has
already been vaccinated...

Medical record review for Resident #7
documented an admission date of 4/2/01 with
diagnoses of Dementia, Diabetes Mellitus II,
Hyperlipidemia, Depressive Disorder, and
Osteoarthritis. Review of a physician's telephone
order dated 10/7/10 documented, "...Flu vac
[vaccine] 0.5 ml [milliliters]..." The facility was
unable to provide documentation that the flu
vaccine had been administered to Resident #7.

During an interview at the side 3 nurse's station
on 11/29/10 at 2:40 PM, Nurse #8 was asked if
Resident #7 received the flu vaccine. Nurse #8
reviewed the medical record and stated, "...It
should have been documented on the MAR
[medication administration record], nurse's notes,
and care plan. I don't see that. I'm not sure that
she got it."

F 371  483.35(I) FOOD PRODUCE,
STORE/PREPARE/serve - SANITARY

The facility must -
(1) Procure food from sources approved or
considered satisfactory by Federal, State or local
authorities; and
(2) Store, prepare, distribute and serve food
under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on policy review, observations, and
interviews, it was determined the facility failed to

F-371
1. Staff members #1 and #3 were immediately in-
serviced on 12/1/2010 by the dietary manager on
proper use of hair nets.
On 11/29/2010 staff members #1 and #2 were in
serviced by the Dietary Manager on the proper
drying of dishes.
2. No residents were identified affected by this
citation.
3. Dietary personnel were in-serviced on 12/1/2010
on proper use of hair nets and hair nets with facial
hair and allowing dishes to air dry by the Dietary
Manager.
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

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<td>F 371</td>
<td>Continued From page 12</td>
<td>F 371</td>
<td>4. The dietary manager and/or cook will monitor proper use of hair nets daily times 2 weeks, 2 times a week for 2 weeks, then weekly times 2 months and/or until 100% compliance obtained. The Dietary Manager and/or Cook will monitor the drying of dishes times 2 days times 2 weeks, 1 times a day times 2 weeks then 1 time a day 3 times a week times 1 month, then 1 time a day 1 time a week for 1 month and/or until 100% compliance obtained. The findings will be reported to the Quality Assurance Committee x 3 months or until 100% compliance is achieved. The Quality Assurance Committee consists of the Administrator, Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, Social Services Department, MDS Team, Maintenance Department, Environmental Services, Medical Records, Rehabilitation Department, Activities, and Medical Director.</td>
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- Ensure that staff had hair and beards covered in the kitchen on 2 of 3 (11/29/10 and 12/1/10) days and that dishes were air dried on 1 of 3 (11/29/10) days of kitchen observations.

The findings included:

1. Review of the facility's "DRESS CODE" policy documented, "...B. Dietary staff...Hair Nets..."

Observations in the kitchen on 11/29/10 at 9:00 AM and 1:55 PM, revealed dietary staff #1 working at the ware-washer and on the tray line. Dietary staff member #1's beard was not covered.

Observations in the kitchen on 12/1/10 at 7:55 AM, revealed dietary staff member #1 was working on the tray line with his beard not covered.

Observations in the kitchen on 12/1/10 at 7:55 AM, revealed dietary staff member #3 stocking supplies in the kitchen. Dietary staff member #3 was wearing a cap that partially covered his hair and his beard was not covered.

Observations in the kitchen on 12/1/10 at 8:15 AM, revealed dietary staff members #1 and #3 were in the kitchen with no beard coverings on and dietary staff member #3's hair was partially uncovered.

During an interview in the kitchen on 12/1/10 at 8:15 AM, the Dietary Manager (DM) was asked about hair coverings. The dietary manager stated, "They [staff members] wear caps but no beard covers. I don't think our policy says anything about beard covers." The dietary manager agreed that the facial hair was not covered.
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| F 371             | Continued From page 13  
2. Review of the facility's "Departmental Policies" documented, "...All pots and pans must be air dried after the final sanitizing rinse..."  
Observations in the kitchen on 11/29/10 at 9:00 AM, revealed dietary staff member #1 was removing clean dishes from the ware washer and drying the dishes with a towel.  
Observations in the kitchen on 11/29/10 at 1:55 PM, revealed dietary staff member #2 was removing clean dishes from the ware washer and drying the dishes with a towel.  
During an interview in the dietary office on 12/1/10 at 8:10 AM, the DM was asked about drying the dishes with a towel. The DM stated, "I thought it was okay to dry if you change towels when they [towels] are damp."  
F 431             | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS |

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.  

F-431             | 1  
Nurse #6 in-serviced on 12/1/2010 by the Director of Nursing on proper storage of medications and locking of medication cart.  
2. All residents have the potential to be affected by this citation. An audit of medication carts was completed on 12/1/2010 by the Director of Nursing and/or Nursing Supervisor, none found unlocked.  
3. Licensed nurses were in-serviced on 12/01/2010 by the Director of Nursing and/or Staff development coordinator regarding storage of medications and locking of medication carts.  

12/01/2010
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<td>F 431</td>
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<td>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>
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<td>4. Audits of the medication carts will be completed by the Director of Nursing and/or Nursing Supervisor 3 times a week for 5 weeks, 2 times a week for 3 weeks, 1 time a week for 4 weeks and/or until 100% compliance obtained. The findings will be reported to the Quality Assurance Committee x 3 months or until 100% compliance is achieved. The Quality Assurance Committee consists of the Administrator, Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, Social Services Department, MDS Team, Maintenance Department, Environmental Services, Medical Records, Rehabilitation Department, Activities, and Medical Director.</td>
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This REQUIREMENT is not met as evidenced by:

Based on policy review, observations, and interviews, it was determined the facility failed to ensure a medication cart was locked and medications were not left unattended in 1 of 8 (Side 2 medication cart) medication storage areas.

The findings included:

Review of the facility's "Storage of Medications" policy documented, "...the facility shall store all drugs and biological in a safe, secure, and orderly manner... Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biological 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."
F 431 Continued From page 15

Observations on side 2 on 11/30/10 at 7:00 AM, revealed the side 2 medication cart was left unattended, unlocked and out of view of the nurse.

Observations on side 2 on 11/30/10 at 7:31 AM, revealed a vial of Novolin 70/30 insulin was sitting on top of side 2's medication cart unattended.

During an interview on side 2 on 11/30/10 at 7:10 AM, the surveyor told Nurse #6 that she had left the side 2 medication cart unlocked. Nurse #6 stated, "I know it's a bad habit, when I just step right in there [referring to resident's room] I forget."

During an interview in the conference room on 12/1/10 at 10:00 AM, the Director of Nursing stated, "Medication cart should always be locked."

F 441 483.65 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
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 policy reviews, observations, and interviews, it was determined 5 of 24 staff members (Certified Nursing Assistants (CNA) #1, CNA #2, Rehabilitation Coordinator, Dietary Manager and Nurse #2) failed to ensure infection control practices were used to prevent the potential spread of infection by not using sanitary hand hygiene or touching food and straws with their bare hands. Two (2) of 6 nurses (Nurses #5 and #6) failed to clean the glucometer with a Super Sani-wipe.

The findings included:
1. Review of the facility's "Hand-hygiene" policy

Licensed nurses certified nursing assistants, dietary department staff, therapy staff, business office staff and housekeeping were in-serviced on 12/10/2010 by the Director of Nursing and/or Staff development coordinator regarding hand hygiene and meal tray set up following infection control policy. Licensed nurses were in-serviced 12/1/2010 on proper method to clean and disinfect glucometer.

Hand hygiene and meal tray set up audits by the director of nursing and/or Nursing Supervisor for following infection control policy will be done 3 times a week times 8 weeks, 2 times a week for 2 weeks and 1 time a week for 2 weeks and/or compliance is obtained. Glucometer cleaning and disinfecting audits by the Director of Nursing and/or Nursing Supervisor 3 times a week for 4 weeks, 2 times 4 weeks, 1 times a week 1 month, and/or until 100% compliance obtained. The findings will be reported 100% compliance obtained.

The findings will be reported to the Quality Assurance Committee x 3 months or until 100% compliance is achieved. The Quality Assurance Committee consists of the Administrator, Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, Social Services Department, MDS Team, Maintenance Department, Environmental Services, Medical Records, Rehabilitation Department, Activities, and Medical Director.
<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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| F 441 | Continued From page 17 documented, "...2. hand washing ... b. after contact ... with non-intact skin... d. before and after eating or handling food... 3. a. before or after direct contact with residents... g. after contact with resident's intact skin... i. after contact with inanimate objects (...equipment) in the immediate vicinity of the resident..."

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| F 441 | Completed from page 17 documented, "...2. hand washing ... b. after contact ... with non-intact skin... d. before and after eating or handling food... 3. a. before or after direct contact with residents... g. after contact with resident's intact skin... i. after contact with inanimate objects (...equipment) in the immediate vicinity of the resident..."

- Observations in room 504 A on 11/30/10 at 7:45 AM, CNA #1 held the toast with his bare hand to put jelly and butter on it.

- Observations in room 504 A on 11/30/10 at 12:45 PM, CNA #1 removed a slice of bread from the wrapper with her bare hands.

- Observations in room 511 B on 11/30/10 at 12:20 PM, CNA #1 removed a slice of bread from the wrapper with her bare hands, opened the straw and touched the straw with her bare hand.

- Observations in room 207 on 11/30/10 at 7:18 AM, CNA #2 repositioned a resident, adjusted the bed with the bed control and moved a box under the bed and then began to set up the tray opening the butter and the sweetener. CNA #2 then began to feed the resident. CNA #2 did not wash her hands prior to tray set up or before she fed the resident.

- Observations in room 202 on 11/30/10 at 7:40 AM, CNA #2 did not wash her hands prior to delivery of the meal tray or prior to opening the milk and butter. CNA #2 left the room and proceeded to get the next tray without washing hands.

- Observations in room 201 on 11/30/10 at 7:45 AM, CNA #2 opened the straw and touched the
Continued From page 18

straw with her bare hand.

Observations in room 202 on 11/30/10 at 7:47 AM, CNA #2 opened the straw and touched the straw with her bare hand.

Observations in room 208 on 11/30/10 at 7:50 AM, CNA #2 repositioned the resident, manipulated the pillow and bed linen and did not wash her hands prior to setting up the food tray. CNA #2 then touched the straw with her bare hand, and began feeding the resident.

c. Observations in the main dining room on 11/30/10 at 11:30 AM, the Rehabilitation Coordinator opened a resident's straw and touched the straw with her bare hand then went to another resident and opened another straw with her bare hand.

d. Observations in the main dining room on 11/30/10 at 11:30 AM, the Dietary Manager opened a resident's straw and touched the straw with her bare hand.

e. During an interview at side 3 nurses' station on 12/1/10 at 7:45 AM, the Staffing Coordinator was asked what is the expectation of staff when passing meal trays. The Staffing Coordinator stated, "Wash hands prior to tray delivery, if touch resident or their environment will need to wash hands again. Don't touch straw or food with bare hands."

f. Observations in Resident #17's room on 11/29/10 at 11:48 AM, revealed Nurse #2 did not wash her hands after administering an injection.

2. Review of the facility's "Blood Glucose Meter"
**F 441 Continued From page 19**

Maintenance Policy & [and] Procedure documented, "...Purpose: The Blood Glucose Meter should be cleaned and disinfected between each resident use... Procedure...2b. Take a clean wipe and thoroughly wipe and wet surface to disinfect. 3. When using the wipes to clean and disinfect the meter...follow all product label instructions. (2 minute dry Super Sani-wipes)..."

- **a. Observations in Random Resident (RR) #5's room on 11/30/10 at 6:35 AM, Nurse #6 cleaned the glucometer with an alcohol pad not with a Super-Sani-wipe as per policy.**

- **b. Observations in Resident #15's room on 11/30/10 at 6:45 AM, Nurse #6 cleaned the glucometer with an alcohol pad not with a Super Sani-wipe as per policy. After use of the glucometer Nurse #6 returned the glucometer to the medication cart drawer without cleaning it.**

- **b. Observations in Resident #7's room on 11/30/10 at 7:00 AM, Nurse #6 did not clean the glucometer prior to or after obtaining a blood glucose on Resident #7. Nurse #6 then entered Resident #16's room at 7:15 AM, Nurse #6 obtained a blood sugar with the same glucometer used on Resident #7 without cleaning it before or after use. Nurse #6 then entered Resident #10's room at 7:20 AM, with the same contaminated glucometer Nurse #6 obtained a blood sugar on Resident #10. Nurse #6 did not clean the glucometer prior to use on each resident nor did she clean the glucometer between residents or after each use.**

During an interview in the conference room on 12/1/10 at 10:00 AM, the Director of Nurses (DON) was asked what is the expectation of
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<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 441</td>
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<td>Continued From page 20, cleaning the glucometer. The DON stated, &quot;They [nurses] should clean it [glucometer] between residents and are to clean it with the Sanif-wipe clothes. We have packets made up and there is no excuse for that <a href="1">not cleaning the glucometer prior to</a> of after each use. They [nurses] can do better.&quot;</td>
<td>F 441</td>
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<td>F 465</td>
<td></td>
<td>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</td>
<td>F 465</td>
<td></td>
<td>F-465 1. Shower #2's drain was cleaned on 11/30/2010 by housekeeping. Shower room #1's bariatric shower chair's belt was changed on 11/30/2010 by maintenance. 2. All residents that use the shower rooms and shower chairs have the potential to be effected by this situation. An audit of shower rooms and shower chairs was completed by 12/1/2010 by the housekeeping supervisor. 3. Licensed nurses and certified nurse assistants were in service on 12/10/2010 on cleaning of shower area post showers and shower chairs by the Director of Nursing and/or Nursing Supervisor. Housekeeping was in-service on 12/10/2010 on proper cleaning of shower rooms and shower chairs by the Housekeeping supervisor. 4. Shower rooms and shower chairs will be audited 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 2 weeks, 5 times a week for 2 weeks and/or until 100% compliance achieved by Housekeeping Supervisor and/or Nursing Supervisor. The findings will be reported to the Quality Assurance Committee x 3 months or until 100% compliance is achieved. The Quality Assurance Committee consists of the Administrator, Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, Social Services Department, MDS Team, Maintenance Department, Environmental Services, Medical Records, Rehabilitation Department, Activities, and Medical Director.</td>
<td>12/17/10</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<td></td>
<td>12/01/2010</td>
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<table>
<thead>
<tr>
<th>NAME OF PROVIDER OR SUPPLIER</th>
<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
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<tbody>
<tr>
<td>TRICOUNTY HEALTHCARE CENTER</td>
<td>ADAMSVILLE, TN 38310</td>
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<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
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| F 465         | Continued From page 21 movement] on the drain."  

2. Observations in Shower #1 on 11/29/10 at 3:35 PM and on 11/30/10 at 3:15 PM, revealed a bariatric shower chair in the shower stall with the safety belts soiled with brown stains.  

During an interview in Shower #1 on 11/30/10 at 3:16 PM, the Housekeeping Supervisor was asked if the shower chair was clean. The Housekeeping Supervisor stated, "No and I wouldn't want that belt around me. It's dirty." | F 465 |                                                                                                           |                |

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**RECEIVED**

**DEC 15 2010**