N 727  1200-8-6-.06(6)(b) Basic Services

   (6) Pharmaceutical Services.

   (b) All internal and external medications and preparations intended for human use shall be stored separately. They shall be properly stored in medicine compartments, including cabinets on wheels, or drug rooms.

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

Tennessee Code Annotated 68-11-804(c)7:
All internal and external medications and preparations intended for human use shall be stored separately. They shall be properly stored in medicine compartments, including cabinets on wheels, or drug rooms. 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 then on duty. Poisons or external medications shall not be stored in the same compartment and shall be labeled as such.

Based policy review, observation and interview, it was determined the facility failed to ensure safe and secure storage of medications in 3 of 8 (1B medication cart, 1A-B split medication cart and 2A medication cart) medication storage areas.

The findings included:

1. Review of the facility’s medication storage policy documented, "...Medications must be properly stored in medication rooms or medication carts..."

Observations on the 1B hallway on 7/17/13 at 3:40 PM, revealed a medication card of Xanax

Drugs and biological used in the facility will be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

1. a. The #9 Xanax tablet from the medication card on the 1B hallway was wasted in a sharps container by the nurse and a witness on 7/17/13.
   b. The bottle of Magnesium Oxide 400 mg from the 1A-B split medication cart was properly disposed of by the nurse on 7/17/13.
   c. The open bottle of insulin from the 2A medication cart dated 5/29 was properly disposed of by the nurse on 7/17/13.

2. The DON and ADON inspected each medication cart to ensure that all medications were stored properly and within the expiration date.

3. The DON in-serviced nurses on 7/17/13 regarding the proper storage of medications and the proper procedure for disposing of expired medications.

4. The DON and ADON will ensure compliance through random medication cart audits and report any abnormal findings to the QA Committee.

7/31/13
<table>
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<tr>
<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>COMPLETE DATE</th>
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</table>
| N 727        | Continued From page 1  
0.25 milligrams (mg) tablets in the 1B medication cart with the #9 tablet taped into the card.  
During an interview on the 1B hallway on 7/17/13 at 3:40 PM, Nurse #1 was asked what the facility's protocol was for handling a Xanax tablet after it was removed from the medication card. Nurse #1 stated "...we would waste it with a witness if it was popped out by mistake...I'm not sure why that is taped..."  
During an interview on the 1A hallway on 7/17/13 at 4:00 PM, Nurse #3 was asked what she would do if she removed a controlled medication from a medication card by mistake.  
During an interview in the Director of Nurse's (DON) office on 7/17/13 at 5:20 PM, the DON was asked what nursing staff should do if they removed a controlled medication from a medication card by mistake. The DON stated, "...they [nurses] would waste it in a sharps container with two nurses witnessing it..."  
2. Review of the facility's medication storage policy documented, "...Routine checks must be accomplished to ensure that expired medications are discarded..."  
Observations on the 1A hallway on 7/17/13 at 4:00 PM, revealed a bottle of Magnesium Oxide 400 mg tablets in the 1A-B split medication cart with a manufacturer's expiration date of 6/13.  
During an interview on the 1A hallway on 7/17/13 at 4:00 PM, Nurse #3 was asked what she would do if she found an expired medication in the medication cart. Nurse #3 stated, "...I would throw it out..." | N 727 | | | |
N 727

Continued From page 2

During an interview in the DON's office on 7/17/13 at 5:20 PM, the DON was asked about the facility's policy for expired medication on the medication cart. The DON stated, "...take it off the cart, put the remainder of medication in a sharps container and get rid of the bottle..."

3. Review of the facility's medication storage policy documented, "...Routine checks must be accomplished to ensure that expired medications are discarded... Whenever the seal of a multi-dose vial of medication is broken it must be initialed and dated by the nurse with an opened date... The vial must be discarded after 28 days unless the manufacturer specifies a shorter expiration date..."

Observations on the 2A hallway on 7/17/13 at 5:45 PM, revealed an opened bottle of insulin in the 2A medication cart with an opened date of 5/29.

During an interview on the 2A hallway on 7/17/13 at 5:45 PM, Nurse #2 was asked how long insulin was good for after it was opened. Nurse #2 stated "...I'm pretty sure a month... I would go and get another one in the refrigerator and let my DON know..." Nurse #2 was asked about the insulin found in the 2A medication cart. Nurse #2 stated, "...It says 5/29 so I would say it's expired..."

During an interview in the DON's office on 7/17/13 at 5:20 PM, the DON was asked how long insulin was good for after it was opened and what nursing staff should do when it has expired. The DON stated, "...28 days...they [nurses] are to destroy it... put it into a sharps container and call pharmacy and order more..."
## Statement of Deficiencies and Plan of Correction

**Provider/Supplier/Clinical Identification Number:** TN5707  
**Multiple Construction**  
A. Building:  
B. Wing:  
**Date Survey Completed:** 07/18/2013

### Name of Provider or Supplier
**West TN Transitional Care**

### Street Address, City, State, Zip Code
**670 Skyline Drive**  
**Jackson, TN 38301**

### ID Prefix TAG

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<tr>
<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>Complete Date</th>
</tr>
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</table>
| N1216         | Continued From page 3                                                                           | N1216         | The facility will keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.  
1. The DON and ADON inspected each laptop and physical record on 7/15/13 to ensure that patient information was kept confidential.  
2. Nurses were in-serviced on 7/24/13 regarding the importance of protecting patient information by ensuring that no patient information is visible while the laptop on the medication carts are unattended.  
3. The DON and ADON will perform random audits of the medication carts to ensure that patient information is not visible while unattended and report any abnormal findings to the QA Committee. | 7/31/13       |
| 1200-8-6-.12(1)(p) Resident Rights | (1) The nursing home shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservation of dignity, individuality and, to the extent medically feasible, independence. Residents and their families or other representatives shall be fully informed and documentation shall be maintained in the resident's file of the following rights:  
(p) To have their records kept confidential and private. Written consent by the resident must be obtained prior to release of information except to persons authorized by law. If the resident lacks capacity, written consent is required from the resident's health care decision maker. The nursing home must have policies to govern access and duplication of the resident's record; | | | |
| N1216         |                                                                                                 | N1216         |                                                                                                 |               |

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Notes:

- Type C Pending Penalty #5
- Tennessee Code Annotated 68-11-804(c)5: Each patient has a right to have the patient's personal records kept confidential and private. The nursing home must have policies to govern access and duplication of the patient's records. Except for those persons authorized by law to inspect the records, written consent by the patient must be obtained before any information can be released. If the patient is mentally incompetent, written consent is required by the patient's legal representative.
- Based policy review, observation and interview, it...
Continued From page 4

was determined the facility failed to ensure the confidentiality of medical information for 2 of 28 (Residents #10 and #207) sampled residents included in the stage 2 review.

The findings included:

1. Review of the facility's "FACILITY NOTICE OF PRIVACY PRACTICES" policy documented, "...Our Pledge regarding your PHI [Personally Identifiable Health Information]... We understand that PHI about you and your health is personal. Protecting medical information about you is important... This notice applies to all of the records of your care generated by this Facility..."

2. Observations on the 2A hallway on 7/15/13 at 5:11 PM, revealed a medication cart with a computer screen which displayed Resident #10's medical information with no nurse in the area. The medical information was in view to anyone who passed by.

3. Observations on the 2A hallway on 7/15/13 at 5:37 PM, revealed a medication cart with a computer screen which displayed Resident #207's medical information with no nurse in the area. The medical information was in view to anyone who passed by.

Observations on the 2A hallway on 7/15/13 at 6:05 PM, revealed a medication cart with a computer screen which displayed Resident #207's medical information with no nurse in the area. The medical information was in view to anyone who passed by.

4. During an interview in the conference room on 7/18/13 at 7:10 AM, the Director of Nursing (DON) was asked what kind of information of the
<table>
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<th>(X5) COMPLETE DATE</th>
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<td>N1216</td>
<td>Continued From page 5</td>
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<td></td>
<td>residents does the facility protect. The DON stated, &quot;Any information... health information...&quot;</td>
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<td></td>
<td>The DON was asked about the information displayed on the computer screens when a nurse leaves the medication cart. The DON stated, &quot;... [medical information is] expected to be minimized... shouldn't be any [medical] information on it [computer screen]...&quot;</td>
<td></td>
</tr>
</tbody>
</table>

| (X2) MULTIPLE CONSTRUCTION |
| A. BUILDING: | |
| B. WING:    | |
| (X3) DATE SURVEY COMPLETED |
| 07/18/2013 |