STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(x1) PROVIDER/SUPPLIER/CLINICIAN IDENTIFICATION NUMBER:

TN 5901

(x2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(x3) DATE SURVEY COMPLETED
03/16/2011

NAME OF PROVIDER OR SUPPLIER

NHC HEALTHCARE, LEWISBURG

STREET ADDRESS, CITY, STATE, ZIP CODE

1653 MOORESVILLE HIGHWAY
LEWISBURG, TN 37091

(x4) ID PREFIX TAG
N 629

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

N 629

(3) Infection Control.

8. Water pitchers, glasses, thermometers, emesis basins, douche apparatus, enema apparatus, urinals, mouthwash cups, bedpans and similar items of equipment coming into intimate contact with patients shall be disinfected or sterilized after each use unless individual equipment for each is provided and then sterilized or disinfected between residents and as often as necessary to maintain them in a clean and sanitary condition. Single use, resident disposable items are acceptable but shall not be reused.

This Rule is not met as evidenced by:

Type C Pending Penalty #31

Tennessee Code Annotated 68-11-804(c)(31):
All nursing homes shall disinfect contaminated articles and surfaces, such as mattresses, linens, thermometers and oxygen tents.

Based on policy review, review of the "Long-Term Care Pocket Guide for Infection Control", observation and interview, it was determined the facility failed to ensure 2 of 9 medication nurses (Nurses #5 and 7) disinfected a nebulizer before placing the nebulizer in a plastic bag.

The findings included:

1. Review of the "Long-Term Care Pocket Guide for Infection Control", page 88, documented, "...Equipment and other articles... Reusable equipment is disinfected after use..."

The Center will ensure equipment coming in intimate contact with patients shall be disinfected or sterilized after each use in accordance with 1200-8-6-.06(3)(b)8.

Regarding Random Patient #6 and Patient #2, DON has scheduled licensed nurse inservice training to discuss the center policy regarding the "Cleaning of Shared Medical Equipment" to include the rinsing of the nebulizer chamber.

In-service training is scheduled for licensed nurses to be conducted by the DON. DON will review the "Cleaning of Shared Medical Equipment" policies to include the rinsing of the nebulizer chamber.

ADON and Nurse Unit Manager will conduct competency check off with each nurse related the proper cleaning of shared medical equipment.

ADON, Nurse Unit manager, and Consultant Pharmacist will perform center wide observation monitors observing medication pass. Observers will be monitoring for proper infection control procedures. Observers will be monitoring for proper infection control procedures.

Division of Health Care Facilities

C. Scott Bridwell

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

RECEIVED
03/25/2011

STATE FORM

S8XT11

MAR 26 2011

CONTINUATION SHEET 1 OF 4
2. Observations in Random Resident (RR) #6's room on 3/14/11 at 7:40 PM, Nurse #5 obtained RR #6's nebulizer machine, opened up the chamber where the medication is placed, poured out a clear liquid, then poured in a unit dose of Duoneb into the chamber, put the mask over RR #6's face and turned the machine on. After the treatment was completed, Nurse #5 placed the mask back into the bag without cleaning the chamber.

3. Observations in Resident #2's room on 3/14/11 at 8:20 PM, Nurse #7 obtained Resident #2's nebulizer machine, opened up the chamber where the medication is placed and poured in a unit dose of Duoneb into the chamber, put the mask over Resident #2's face and turned the machine on. After the treatment was completed Nurse #7 placed the mask back into the bag without cleaning the chamber.

4. During an interview in the conference room on 3/15/11 at 4:20 PM, the Director of Nurses (DON) confirmed that the chamber of the nebulizer machine should be rinsed out after each use.

5. In accordance with State and Federal laws, the center will store all drugs and biological in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

   Nurse #2 locked the cart upon identification that the cart was unlocked.

   3/14/11

   This Rule is not met as evidenced by:
   Type C Pending Penalty #7
**N 728 Continued From page 2**

Tennessee Code Annotated 68-11-804(c)?

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.

Based on policy review, observation, and interview, it was determined 2 of 6 (200 hall medication cart and 300 hall medication cart) medication storage areas failed to have medication stored properly when medication was left on top of a medication cart and a medication cart was left unlocked and unattended.

The findings included:

1. Review of the facility’s "Medication Storage“ policy documented, "...5. Individual patient medications shall be stored in an orderly manner in locked unit dose carts... 10. Medication rooms, carts and treatment carts or trays shall be kept locked when it is not in a nurse's immediate view..."

2. Observations in the 200 hall on 3/14/11 at 12:05 PM, revealed the 200 hall medication cart was left unlocked, unattended and out of the nurse's view. Nurse #2 came out of room 205 and stated, "Oh! I'm sorry..."

3. Observations in the 300 hall on 3/14/11 at 6:45 PM, revealed Nurse #4 left a single dose vial of Albuterol Sulfate on top of the 300 medication cart unattended and out of the nurse's view.

<table>
<thead>
<tr>
<th>N 728</th>
<th>Nurse #2 reported to DON that she had left the cart unlocked. DON reviewed the Medication Storage policy with Nurse #2.</th>
<th>3/14/11</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Nurse #4 secured the single dose vial of Albuterol Sulfate upon identification of it on top of the cart. Nurse #4 reviewed the incident with DON. DON reviewed the Medication Storage policy with Nurse #4.</td>
<td>3/15/11</td>
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<td></td>
<td>Licensed nurses will be in-serviced on the center’s Medication Storage policy by the DON to ensure a clear understanding of the policy by all nurses.</td>
<td>4/1/11</td>
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<td></td>
<td>ADON, Nurse Unit Manager and Consultant Pharmacist will perform Medication Pass Review on 10% of the in-house patients observing nurses compliance with Medication Storage Policy. Observations will be conducted weekly X 4 and the Monthly X 2 until no trending is noted. Observations will be presented to the Center's Quality Assurance Committee comprised of the Administrator, DON, Medical Director, (3) physicians, ADON, Medical Records, Social Services, and Rehab Coordinator. The Quality Assurance Committee will make recommendations and develop a plan of action if an area of non-compliance is noted.</td>
<td>3/31/11 ongoing</td>
</tr>
</tbody>
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N 728  Continued From page 3

During an interview in the 300 hall on 3/14/11 at 5:50 PM, Nurse #4 stated, "...I was going to put it [Albuterol Sulfate] back up, I just did not do it..."