<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>N 687</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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<td>N 687</td>
<td>1200-8-6-.06(4)(k) Basic Services (4) Nursing Services. (k) When non-employees are utilized as sitters or attendants, they shall be under the authority of the nursing service and their duties shall be set forth clearly in written nursing service policies. This Rule is not met as evidenced by; Based on policy review, observations and interview, it was determined the facility failed to ensure sitters followed the policy for care of the individual residents, and to ensure that all sitter in the facility were free of communicable disease. The findings included: Review of the facility's &quot;Private Duty Nurses or Sitters&quot; policy documented &quot;...1. Our Director of Nursing [DON] must approve all sitters and relief sitters. 2. Your place of duty is in the room with the resident at all times, except when walking or pushing the resident in a wheelchair... 6. Sitters are not to give care or assistance to other residents... 9. All sitters must have either a negative TB [tuberculosis] skin test or a negative chest X-ray (if skin test is positive) prior to beginning duty and yearly thereafter...&quot; Observations in Resident #10's room during tour on 7/19/10 at 10:22 AM, revealed the resident in bed with a sitter at the bedside. The sitter told the surveyor that she comes in about three hours a day. Observations in Resident #10's room on 7/20/10 at 7:30 AM, revealed the sitter crossing the hallway from another resident's room, and entering Resident #10's room. At 7:50 AM, the sitter was observed feeding the resident a pureed meal.</td>
<td>N 687</td>
<td>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #10's sitter reviewed and signed sitter policy with Director of Social Services on 8/4/10. The sitter also obtained negative TB skin test results from a community health professional on 8/2/10 and submitted these results to the Social Services Director on 8/2/10. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Director of Social Services met with each unit's nurse manager and/or nurse supervisor on 7/28/10 to determine if there are any other unidentified sitters with current residents. Those identified met with Director of Social Services to review and sign sitter policy on 8/2/10. Those identified obtained a negative TB skin test or chest x-ray as appropriate from a community health professional on 8/2/10 and submitted these results to the Social Services Director on 8/2/10.</td>
<td>8/4/10</td>
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<td>N 687</td>
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<td>diet with nectar thickened liquids. The sitter told the surveyor that she comes in about three hours a day. At 11:00 AM, the sitter remained at the resident's bedside. During an interview in the private dining room on 7/22/10 at 4:20 PM, the DON was asked for the file on the sitter for Resident #10. The DON indicated that she was not aware the sitter was coming in a taking care of the resident, but that she would find out if the Social Service Director (SSD) had information on the sitter. During an interview in the private dining room on 7/22/10 at 5:45 PM, the SSD brought a background check done on the sitter. A copy of the TB skin test provided by the facility was dated as read on 1/4/08. There was no documentation of a TB skin test or chest X-ray since the one dated 1/4/08.</td>
<td>What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? A notice of sitter policy was included in the admission packet by the Executive Director on 7/30/10 to be reviewed with each new admission by the staff member completing the admission packet. Staff was instructed on 8/2/10 and 8/3/10 by the Director of Social Services and ADON regarding the sitter policy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The sitter files will be audited monthly times three by the Social Services Director to ensure compliance with the sitter policy and procedures. These results will be reviewed at the performance improvement meeting by the interdisciplinary team (Medical Director, Administrator, DON, Activities Director, ADON, Rehab Services Manager, Director of Food and Nutritional Services, Social Services Director, Wound Care/Infection Control Nurse, Staff Development Coordinator, Maintenance Director, and Director of Environmental Services) monthly times three.</td>
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<td>N 727</td>
<td>727</td>
<td>1200-8-6-.06(5)(b) Basic Services</td>
<td>(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.</td>
<td>This Rule is not met as evidenced by: 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</td>
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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

When on duty.

This Rule is not met as evidenced by:

Based on policy review, observation and
interview, it was determined the facility failed to
ensure 2 of 3 (Nurses #1 and 2) nurses observed
during medication administration kept unlocked
medications under continuous nurse supervision.

1. Review of the facility's "Chapter 4: Policy A
Guide to Medication Utilization Medication
Storage" policy documented, "...Medications must
be kept under continuous supervision..."

2. Observations on the south hall on 7/20/10
beginning at 7:59 AM, Nurse #1 entered Resident
#14's room to administer oral medications, and
left the resident's eye drops and inhaler on top of
the medication cart unattended and out of the
nurse's line of vision. Nurse #1 returned to the
medication cart to get the glucometer, re-entered
Resident #14's room and left the eye drops and
Inhaler unattended on top of the medication cart
and out of the nurse's line of vision for the second
time. After obtaining the accucheck, Nurse #1
returned to the medication cart to draw up
Resident #14's insulin, re-entered the room to
administer the insulin, and again left the eye
drops and inhaler on top of the medication cart
unattended and out of the nurse's line of vision.

3. Observations in Room 126B on 7/20/10 at
10:25 AM, Nurse #2 left Random Resident (RR)
#1's medications (Vitamin D and Ferrous Sulfate)

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What corrective action(s) will be
accomplished for those residents found to
have been affected by the deficient
practice?

Nurse #1 was educated on 8/3/10 by
ADON regarding
keeping unlocked medications under
continuous supervision.
Nurse #2 was educated on 7/28/2010 by
DON regarding keeping
unlocking medications under continuous
supervision.

How will you identify other residents
having the potential to be affected by the
same deficient practice and what corrective action will be taken?

Residents receiving medication have the
potential to be affected by this deficient
practice.
Licensed Nurses were in-service by the
Staff
Development Coordinator, ADON, DON on
7/25/2010, 7/27/2010, 8/2/10, 8/3/10
regarding keeping unlocked medications
under continuous supervision.

What measures will be put into place or
what systematic changes will you make to
ensure that the deficient practice does not
recur?

Quarterly in-servicing for licensed staff for one
year regarding keeping unlocked medications
under continuous supervision.
This will be completed by
The DON, ADON, and/or Staff Development
Coordinator.
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  on RR #1's overbed table when she left the room to obtain a towel. The medication was unsupervised and out of the nurses line of vision.  
  4. During an interview in the private dining room on 7/21/10 at 4:15 PM, the Director of Nursing stated, "...No [nurses should not leave medications unattended out of their line of vision]..." | N 727 | How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.  
  A nurse from each unit will be monitored weekly for four weeks and then monthly for three months to ensure that medications are being kept under continuous supervision when not secured in the medication cart. These monitors will be completed by the Director of Nursing, Assistant Director of Nursing, and the Unit Managers. These results will be reviewed at the performance improvement meeting by the interdisciplinary team (Medical Director, Administrator, DON, Activities Director, ADON, Rehab Services Manager, Director of Food and Nutritional Services, Social Services Director, Wound Care/Infection Control Nurse, Staff Development Coordinator Maintenance Director, and Director of Environmental Services, Admissions/Marketing Director) monthly times four and when needed thereafter to ensure continued compliance. |