F 241 (D) Dignity and Respect of Individuality

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

Based on policy review, observation and interview, it was determined that staff did not provide appropriate seating in proportion to the table height for 1 of 16 residents in the dining room.

The findings included:

1. Review of the facility's "Feeding A Resident" policy documented, "...Procedure... Sit to feed the resident..."

a. Observations in room 314B, on the ASU, on 10/10/11 at 5:15 PM, Certified Nursing Assistant (CNA) #2 stood at the bedside to feed the resident.

b. Observations in room 312A, on the ASU, on 10/10/11 at 5:40 PM, CNA #1 stood at the bedside to feed the resident.

c. Observation in room 319A, on the ASU, on 10/11/11 at 12:23 PM, Nurse #8 stood at the bedside to feed the resident.

2. Review of the facility's "Feeding A Resident" procedure policy documentation.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting if it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are subject to disclosure 30 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.
### F 241
Continued from page 1

Policy documented, "...Procedure... Assess residents for... correct table..."

Observations in the ASU dining room on 10/10/11 at 5:07 PM and on 10/11/11 at 11:55 AM, revealed a resident seated in a wheelchair. The resident's chin was level with the table top.

3. During an interview in the Director of Nursing's (DON) office on 10/12/11 at 4:55 PM, the DON confirmed that staff should be seated when feeding the residents. When asked what an appropriate height of a dining table in proportion to the wheelchair should be, the DON stated, "Depends on height of resident and wheelchair... will check to see if the tables in ASU can be adjusted."

### F 278
SS=D
483.20(g) - (l) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than
F 278 Continued From page 2
$1,000 for each assessment; or an individual who
willfully and knowingly causes another individual to
certify a material and false statement in a
resident assessment is subject to a civil money
penalty of not more than $5,000 for each
assessment.

Clinical disagreement does not constitute a
material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interviews, it
was determined the facility failed to ensure the
Minimum Data Set (MDS) assessments were
accurate by not assessing residents for falls for 2
of 21 (Residents #9 and 10) sampled residents.

The findings included:

1. Medical record review for Resident #9
documented an admission date of 8/19/11 and a
readmission date of 9/13/11 with diagnoses of
Hypertension, Congestive Heart Failure, Distal
Radial Fracture and Dementia with Behavior
Disturbance. Review of Resident #9's care plan
dated 9/9/11 documented, "...Potential for fall due
to weakness and poor mobility..." Review of the
nurses' notes and incident report documented a
fall on 9/15/11 with a fractured left distal radius
and chest contusion. Review of the 14-day
scheduled MDS assessment dated 9/23/11
documented, "...Section J, Health Conditions...
J1800 Any Falls Since Admission or Prior
Assessment" was coded "...0...", indicating no
falls.
**F 278**

Continued From page 3

During an interview in the private dining room on 10/12/11 at 3:00 PM, Nurse #3 was asked about the fall not being documented on the 9/23/11 MDS assessment. Nurse #3 stated, "I missed it."

2. Medical record review for Resident #10 documented an admission date of 6/2/11 and a readmission date of 8/11/11 with diagnoses of Pneumonia, Atrial Fibrillation, Shortness of Breath, Hypertension, Esophageal Reflux, Congestive Heart Failure, Cardiovascular Disease, Hypothyroidism and Depressive Disorder. Review of Resident #10's nurses' notes and incident report documented a fall on 8/7/11 with a left hip fracture, left head contusion and left orbit laceration. Review of the quarterly scheduled MDS assessment dated 8/31/11 documented, "...Section J, Health Conditions... J1800 Any Falls Since Admission or Prior Assessment" was coded "...0...", indicating no falls.

During an interview in the private dining room on 10/12/11 at 2:50 PM, Nurse #5 was asked about the fall not being documented on the 8/31/11 MDS assessment. Nurse #5 stated, "I missed it."  

**F 280**

483.20(d)(5), 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
F 280 Continued From page 4
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, observation and interview, it was determined the facility failed to revise the care plan for 3 of 24 (Residents #3, 6 and 9) sampled residents.

The findings included:
1. Review of the facility's "MEDICARE SUPPORT CENTER RESIDENT CARE PLAN" policy documented, "...Each care plan must include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that have been identified in the comprehensive assessment... Incomplete or inaccurate care plans may not appropriately reflect the care provided to our residents..."

2. Medical record review for Resident #3 documented an admission date of 8/24/05 with diagnoses of Hypertension, Gastroesophageal Reflux Disease, Dementia, Anxiety, Depression and Osteoarthritis. Review of the quarterly Minimum Data Set (MDS) dated 7/4/11.

F 280 F - 289 (D) Right to Participate Planning Care – Revise CP

1. The following corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

   1. The facility has revised the care plans for Residents #3, #6, and #9:
      a. Bowel and bladder incontinence was added to the care plan of resident #3 on October 12, 2011 by the MDS Coordinator;
      b. Resident #6's care plan was updated on October 21, 2011 by MDS Coordinator to reflect current isolation status and NPWT wound care as ordered;
      c. Resident #9's care plan was updated on October 21, 2011 by the MDS Coordinator to include dementia with behavior and use of Ativan.

2. How other residents are identified as having the potential to be affected by the same deficient practice and what corrective action will be taken:

   2. MDS Coordinators will review resident charts from October 26, 2011 through November 2, 2011 to confirm that care plans are accurate and complete with respect to bowel and bladder incontinence, current isolation status, and use of psychotropic medications.

3. What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur:
<table>
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<th>F 280</th>
<th>Continued From page 5</th>
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|       | documented, "...SECTION H. Bladder and Bowel...H0300. Urinary Continence...2...2. Frequently incontinent...H0400. Bowel Continence...2...2. Frequently Incontinent..." and the annual MDS dated 9/23/11 documented, "...SECTION H Bowel and Bladder...H0300. Urinary Continence...2...2. Frequently incontinent...H0400. Bowel Continence...1... Occasionally incontinent..." Review of the care plan dated 9/28/11 documented no care plan for bowel and bladder incontinence. During an interview in the private dining room on 10/12/11 at 2:50 PM, Nurse #5 was asked if Resident #3 should have a care plan addressing her bowel and bladder incontinence. Nurse #5 stated, "...Absolutely..."

| F 289 | 3. MDS Coordinators will review of resident care plans monthly x 3 months and confirm complete, accurate, and appropriate care plans reflecting the care plans are accurate and complete with respect to bowel and bladder incontinence, current isolation status, and use of psychotropic medications.

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: what quality assurance program will be put into place:

4. DON will present results of monthly care plan accuracy reviews to the PI committee for 3 months.

NOTE: the Performance Improvement Committee (PI Committee) meets monthly and consists of the Medical Director, Director of Nursing (DON), Social Services Director, Activities Director, Rehab Services Manager, Director of Food and Nutrition Services, Medical Records Director, and Executive Director (Administrator). Business Office Manager, ESM, Maintenance.
Continued From page 6
the NPWT wound care as ordered.

Observations in room 233 on 10/10/11 at 6:45 PM, revealed that Resident #6 was no longer in contact isolation.

4. Medical record review for Resident #9 documented an admission date of 8/19/11 with a readmission date of 9/19/11 with diagnoses of Hypertension, Congestive Heart Failure, Dementia with Behavior Disturbance and Distal Radial Fracture. Review of the physician's orders dated 10/3/11 documented, "...Ativan 1 mg [milligram] P.O. [by mouth] Q [every] 4 [symbol]
for hour] PRN [as needed] r/t [related to]
Agitation..." Review of the care plan dated 9/9/11 was not updated to include Dementia with behavior disturbance and there was no mention of the antidepressant medication Ativan.

During an interview in the private dining room on 10/12/11 at 3:00 PM, Nurse #3 was asked about the Ativan and Dementia with behavior disturbance not being on the care plan. Nurse #3 stated, "...The nurse that took the order should have added it [Ativan and Dementia with behavior disturbance] to the care plan..."

F 309 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.

F 309 (D) Provide Care/Services for Highest Well Being

1. The following corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

1. LPN Unit Manager reconciled recertification orders for resident #10 for physical therapy on October 26, 2011. LPN Unit Manager reconciled recertification orders for resident #17 for dialysis on October 26, 2011. LPN Unit Manager reconciled recertification order for resident #18 for dialysis on October 26, 2011.

2. How other residents are identified as having the potential to be affected by the same deficient practice and what corrective action will be taken:

2. RN/LPN Unit Managers or designees will reconcile recertification orders for facility residents beginning October 24, 2011 through October 31, 2011. Orders will be reconciled appropriately.

3. What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur:

3. DON, ADON, RN/LPNs will audit reconciled recertification orders for 15 facility residents monthly x 3 months to confirm accuracy and completion of the recertification orders.
**LIFE CARE CENTER OF COLUMBIA**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
541 W. JAMES CAMPBELL BLVD.
COLUMBIA, TN 38401

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### F 309 Continued From page 7

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review and interview, it was determined the facility failed to reconcile recertification (recert) orders for dialysis and/or physical therapy for 3 of 24 (Residents #10, 17 and 18) sampled residents.

The findings included:

1. Review of the facility's "Medication Reconciliation across the Continuum of Care" policy documented, "...1. On a monthly basis at the end of every month, medications are reconciled as part of the ongoing updating of physician orders."

2. Medical record review for Resident #10 documented an admission date of 6/2/11 and a readmission date of 8/11/11 with diagnoses of Pneumonia, Atrial Fibrillation, Shortness of Breath, Hypertension, Esophageal Reflux, Cardiovascular Disease, Congestive Heart Failure, Hypothyroidism and Depressive Disorder. Review of a physician's order dated 9/21/11 documented, "...P.T. [physical therapy] Clarification Order - Effective 9/14/11, continue P.T. services 7 x [times] week for 1 week, and 5 x week for 3 weeks." Review of the physician's recertification orders dated 10/8/11 did not include the orders for PT services.

During an interview at the North hall nurses' station on 10/12/11 at 8:40 AM, Nurse #4 was asked about the PT orders. Nurse #4 stated, "...should [PT] have been put on the recert orders..."
### Statement of Deficiencies and Plan of Correction

**Provider/SupPLIER/CRC**

- **Identification Number:** 445236

**Multiple Construction**

- **Building:**
- **Wing:**

**Date Survey Completed:** 10/12/2011

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**Name of Provider or Supplier:**

- **Life Care Center of Columbia**

**Street Address, City, State, Zip Code:**

- **541 W. James Campbell Blvd., Columbia, TN 38401**

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**ID Prefix TAG** | **Summary Statement of Deficiencies** (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)** | **ID Prefix TAG** | **Provider’s Plan of Correction** (Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)** | **Completion Date**
--- | --- | --- | --- | ---
**F 309** | Continued From page 8

3. Medical record review for Resident #17 documented an admission date of 5/25/11 with diagnoses of Hypertension, End Stage Renal Disease, Diabetes Mellitus, and Depression.

   Review of the physician's admission orders dated 9/7/11 documented, "Dialysis MWF [Monday, Wednesday, Friday] at [named dialysis facility]..."

   Review of the physician's recertification orders dated 10/8/11 did not include orders for dialysis.

   During an interview at the North hall nurses' station on 10/12/11 at 11:15 AM, Nurse #4, was asked about a current order for dialysis. Nurse #4 stated, "...it [dialysis order] wasn't picked up. I don't see it on the recent [recertification] orders..."

4. Medical record review for Resident #18 documented an admission date of 5/27/10 with a readmission date of 10/10/10 with diagnoses of End Stage Renal Disease, Hypothyroidism, Depression, Hypercholesterolemia, Hypertension, and Osteoporosis.


   During an interview at the North nurses' station on 10/12/11 at 1:10 PM, Nurse #4, verified that there was no order on the current recert orders for dialysis. Nurse #4 stated, "...the [dialysis] order did not get carried over..."

**F 322** | 483.25(g)(2) NG Treatment/Services - Restore EATING SKILLS

Based on the comprehensive assessment of a

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**F - 322 (D) NG Treatment/Services - Restore Eating Skills**

1. The following corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

   1. Deficient technique for Resident #3 was reviewed with Nurse #1 by the Director of Nursing and Staff Development Coordinator on October 20, 2011. Nurse #1 was educated on clean technique when administering medications, including for Resident #3, via PEG tube. Expectations of performance utilizing clean technique were clearly defined. Nurse #1 completed a return demonstration on proper technique regarding PEG tube medication administration on October 26, 2011.

2. How other residents are identified as having the potential to be affected by the same deficient practice and what corrective action will be taken:

   2. SDC/RN Unit Managers will complete education with RNs/LPNs on the proper technique of medication administration via a PEG tube from October 27, 2011 through November 7, 2011.

3. What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur:

   3. RN/LPN unit managers will complete monthly review of nurses' performances using proper medication administration
<table>
<thead>
<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>(X5) COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 322        | Continued From page 9 resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. | F 322        | techniques for residents who have PEG tubes for three (3) consecutive months until proficiency is determined.  
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: what quality assurance program will be put into place:  
4. DON will present results of monthly audit of nurses' performances using proper medication administration techniques for residents who have PEG tubes to the PI committee for 3 months.  
NOTE: the Performance Improvement Committee (PI Committee) meets monthly and consists of the Medical Director, Director of Nursing (DON), Social Services Director, Activities Director, Rehab Services Manager, Director of Food and Nutrition Services, Medical Records Director, and Executive Director (Administrator), Business Office Manager, ESM, Maintenance. | 10/12/2011 |

This REQUIREMENT is not met as evidenced by:
Based on review of the "GERIATRIC MEDICATION HANDBOOK" provided by the American Society of Consultant Pharmacists, medical record review, observation and interview, it was determined the facility failed to ensure staff followed clean technique when administering medications per Percutaneous Endoscopy Gastrostomy Tube (PEG) for 1 of 1 (Resident #3) residents observed during medication administration with a PEG tube.

The findings included:

1. Review of the "GERIATRIC MEDICATION HANDBOOK, TENTH EDITION", provided by the American Society of Consultant Pharmacists, on page 64 documented, "...11. Remove plunger from the 60ml [milliliter] syringe and connect syringe to clamped tubing. 12. Put 15–[to] 30ml of water in syringe and flush tubing using gravity flow. Clamp tubing after the syringe is empty, allowing water to remain in the tube... 13. Pour dissolved/diluted medication in syringe and unclamp tubing, allowing medication to flow by gravity. 14. If administering more than one medication, flush with 5ml of water, or prescribed amount, between each medication. 15. Once all
Continued From page 10
medications have been administered, flush tubing with 15-30ml of water, or prescribed amount. Allow water to remain in tubing... 16. Clamp tubing and detach syringe..."

2. Medical record review for Resident #3 documented an admission date of 8/24/06 with diagnosis of Hypertension, Gastroesophageal Reflux Disease, Dementia, Anxiety, Depression and Osteoarthritis. Review of the physician's orders dated 10/3/11 documented, "...COLCrys F/C 0.6 MG [milligram] TABLET 1 TAB [tablet] PER TUBE EVERY DAY... 10 AM... LISINOPRIL 5 MG TABLET... 1 TAB PER TUBE EVERY DAY... 10 AM... THERA TABLET... 1 TAB PER TUBE EVERY DAY... 10 AM...CALCIIUM 600 + [plus vitamin] D 600MG-200 TABLET... 1 TAB PER TUBE TWICE DAILY... 10 AM..."

Observations in Resident #3's room on 10/11/11 at 10:50 AM revealed the following:

a. Nurse #1 flushed the PEG tube with 30 cubic centimeters (cc) of water per gravity, pulled up Therav tablet in the syringe, placed his gloved finger over the tip of syringe and pulled out the plunger, placed the plunger on the bed then placed tip of syringe into PEG and attempted to let the medication flow in without success. Nurse #1 placed the plunger from the bed in the syringe and applied pressure, then pulled up 20 cc of water and flushed using the plunger. Medication residue was noted in the cup.

b. Nurse #1 pulled up Colcrys F/C in the syringe, placed his gloved finger over the tip of the syringe, pulled out the plunger and placed the plunger on the bed. The medication poured out onto Resident #3's clothes when Nurse #1 attempted to place the syringe tip in the PEG.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CJA IDENTIFICATION NUMBER: 445236

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED: 10/12/2011

NAME OF PROVIDER OR SUPPLIER
LIFE CARE CENTER OF COLUMBIA

STREET ADDRESS, CITY, STATE, ZIP CODE
841 W. JAMES CAMPBELL BLVD., COLUMBIA, TN 38401

(X4) ID PREFIX TAG

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

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

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<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 322</td>
<td>Continued From page 11. There was no barrier between the PEG and Resident #3's clothes. Nurse #1 placed the plunger from the bed into the syringe and pulled up 20 cc of water and pushed in the PEG. c. Nurse #1 pulled up Calcium D in the syringe, placed his gloved finger over the tip of the syringe, pulled out the plunger (held plunger in his hand), placed the syringe tip in the PEG. The medication did not flow. Nurse #1 placed the plunger in the syringe and applied pressure. Medication residue was noted in the cup. d. Nurse #1 pulled up Lisinopril in the syringe, placed his gloved finger over the tip of the syringe, pulled out the plunger (held plunger in his hand), placed the syringe tip in the PEG. The medication did not flow. Nurse #1 placed the plunger in the syringe and applied pressure. Nurse #1 pulled up 20 cc of water and removed the plunger, placed the plunger on the bed, placed the syringe in the PEG and allowed the water to flow by gravity. During an interview in the North hall on 10/11/11 at 11:20 AM, Nurse #1 confirmed he did place the syringe plunger on the bed without a barrier and he did use the plunger to push and apply pressure to get medications in the PEG.</td>
<td>F 332 (D) Free of Medication Error Rates of 5% Or More</td>
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1. The following corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

1. Medication procedures contributing to the error rate for Resident #3 were reviewed with Nurse #1 by the Director of Nursing and Staff Development Coordinator on October 20, 2011. Nurse #1 was educated on medication administration times and on ensuring that all medications are removed from medication cups when administering medications to a tube fed resident (e.g. Resident #3), including refraining from leaving residues and completing the medication pass timely. Nurse #1 completed a return demonstration on the proper technique, ensuring that all medications are removed from medication cups when administering medications to a tube fed resident on October 26, 2011.

2. How other residents are identified as having the potential to be affected by the same deficient practice and what corrective action will be taken:

2. RN/LPN Unit Managers will complete education with RN/LPN nursing staff on proper medication administration technique including refraining from leaving residues, and completing timeliness of medication administration from October 27, 2011 through November 7, 2011.

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,
**Summary Statement of Deficiencies**

- **ID**: F 332
- **Tag**: Continued From page 12

Observation and interview, it was determined the facility failed to ensure 1 of 9 (Nurse #1) nurses administered medications with a medication rate of less than 5 percent (%). A total of 3 errors were observed out of 40 opportunities for error, resulting in a medication error rate of 7.5%.

The findings included:

1. Review of the facility's "6.2 Medication Administration Times" policy documented, "...Facility should commence medication administration within sixty (60) minutes before the designated times of administration and should be completed by sixty (60) minutes after the designated times of administration..."

2. Medical record review for Resident #3 documented an admission date of 9/24/06 with diagnoses of Hypertension, Gastroesophageal Reflux Disease, Dementia, Anxiety, Depression and Osteoarthritis. Review of the physician's orders dated 10/3/11 documented, "...CLOCRYS F/C 0.6 MG [milligram] TABLET 1 TAB [tablet] PER TUBE EVERY DAY...10 AM...THERA TABLET... 1 TAB PER TUBE EVERY DAY...10 AM...CALCIUM 600 + [plus vitamin] D 600MCG-200 TABLET... 1 TAB PER TUBE TWICE DAILY...10 AM..."

Observations in Resident #3's room on 10/11/11 at 10:50 AM, Nurse #1 administered a Thera tablet and a Calcium + D tablet crushed and diluted in 2 separate medication cups per Percutaneous Endoscopy Gastrostomy Tube (PEG) tube. Observation of the medication cups revealed residual medication left in both cups, Failure to administer all of the Thera tablet and

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<tr>
<td>F 332</td>
<td>3. What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur:</td>
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<td>3. RN/LPN Unit Managers will complete monthly reviews of nurses' performances on proper medication administration technique including refraining from leaving residues, and completing timeliness of medication administration techniques for residents who have PEG tubes for three (3) consecutive months until proficiency is determined.</td>
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<td>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:</td>
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<td></td>
<td>4. DON will present results of monthly audit of nurses' performances on refraining from leaving residues, and completing timeliness of medication administration techniques for residents who have PEG tubes to the PI committee for 3 months.</td>
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</table>
| | **NOTE:** the Performance Improvement Committee (PI Committee) meets monthly and consists of the Medical Director, Director of Nursing (DON), Social Services Director, Activities Director, Rehab Services Manager, Director of Food and Nutrition Services, Medical Records Director, and Executive Director (Administrator). Business Office Manager, ESM, Maintenance.
### F 332
Continued from page 13
Calcium + D resulted in medication error #1 and medication error #2.

Observations in Resident #3's room on 10/11/11 at 11:18 AM, Nurse #1 administered Colcrys F/C per PEG tube. The failure to administer the Colcrys F/C within one hour of scheduled time of 10 AM resulted in medication error #3.

During an interview in the North hall on 10/11/11 at 11:20 AM, Nurse #1 confirmed Resident #3 did not receive all of the Thera tablet and the Calcium + D and the Colcrys was given 18 minutes past the scheduled time.

### F 362
483.35(S) SUFFICIENT DIETARY SUPPORT PERSONNEL

The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.

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The requirement is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to deliver meal trays in a timely manner during 2 of 2 (10/10/11 and 10/11/11) dining observations.

The findings included:

1. Observations on the Alzheimer's Skilled Unit (ASU) on 10/10/11 at 5:05 PM, revealed the meal cart arrived and the staff began to serve the meal trays. The last meal tray was served at 6:10 PM. A total of 65 minutes had lapsed since the meal cart arrived on the unit.

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**F-362 (D) Sufficient Dietary Support Personnel**

1. The following corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

   1. The RN Unit Manager will complete education with ASU RNs, LPNs, and CNAs on the dining service timeliness policy from October 27, 2011 to November 7, 2011.

2. The RN Unit Manager will complete education with RNs, LPNs, and CNAs on the dining service timeliness policy from October 27, 2011 to November 7, 2011.

3. What measures will be put in place or what systematic changes will be made to ensure the deficient practice does not recur:

   1. The ASU RN Unit Manager will observe ASU dining service for one meal per week for 3 consecutive months for timeliness of meal service and correct any issues noted. The ADON will observe main facility dining service for one meal per week for 3 consecutive months for timeliness of meal service and correct any issues noted.
F 362 Continued From page 14

2. Observations on ASU on 10/11/11 at 11:45 AM, revealed the meal cart arrived and the staff began to serve the meal trays. The last tray was served at 12:23 PM. A total of 38 minutes had lapsed since the meal cart arrived on the unit.

3. During an interview in the Director of Nursing's (DON) office on 10/12/11 at 4:55 PM, the DON stated, "Meals are delivered by the CNA's [certified nursing assistants] on the ASU and should be delivered timely..."

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...
**F 441** Continued From page 15
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 review, observation and interview, it was determined the facility failed to ensure 1 of 3 (Nurse #2) nurses disposed of sharps properly into a designated container.

The findings included:

1. Review of the facility's "Contaminated Sharps" policy documented, "...Contaminated sharps are discarded immediately or as soon as possible in containers that can close and are puncture-resistant, leak proof on sides and bottoms..."

2. Observations in room 323A on 10/10/11 at 5:05 PM, Nurse #2 discarded a clean lancet and strip in the trash, obtained a new lancet and strip, performed the fingerstick, removed and folded her glove around the contaminated lancet and strip and discarded them in the trash.

3. During an interview in room 323A on 10/10/11
<table>
<thead>
<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-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 441</td>
<td>Continued From page 16 at 5:08 PM, Nurse #2 confirmed that the lancet was folded up in her glove and placed in the garbage.</td>
<td>4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur: what quality assurance program will be put into place:</td>
<td></td>
<td></td>
<td>4. The DON will present results of weekly sample audits of RNs and LPNs properly placing sharps into designated sharps containers to the PI committee for 3 months. NOTE: the Performance Improvement Committee (PI Committee) meets monthly and consists of the Medical Director, Director of Nursing (DON), Social Services Director, Activities Director, Rehab Services Manager, Director of Food and Nutrition Services, Medical Records Director, and Executive Director (Administrator). Business Office Manager, ESM, Maintenance.</td>
<td></td>
</tr>
</tbody>
</table>