**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID</th>
<th>PROVIDER/SUPPLIER/CLA</th>
<th>IDENTIFICATION NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 280</td>
<td>SIGNATURE HEALTHCARE OF COLUMBIA</td>
<td>445466</td>
</tr>
</tbody>
</table>

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1410 TROTWOOD AVENUE
COLUMBIA, TN 38401

**DATE SURVEY COMPLETED:**

12/08/2010

---

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

<table>
<thead>
<tr>
<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>(D) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 280</td>
<td>SS-D</td>
<td>483.20(q)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP Plan</td>
<td></td>
</tr>
</tbody>
</table>

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 medical record review and interview, it was determined the facility failed to revise the comprehensive care plan for care of emergency bleeding for 1 of 24 (Resident #4) sampled residents.

The findings included:

Medical record review for Resident #4 documented an admission data of 9/2/10 with diagnoses of End Stage Renal Disease, Atrial Fibrillation, Hypertension, and Arthrophy. Review of the care plan dated 9/24/10

---

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

**DATE:** 12/23/10

---

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 discoverable 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 discoverable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.
F 280
SS=O
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 medical record review and interview, it was determined the facility failed to revise the comprehensive care plan for care of emergency bleeding for 1 of 24 (Resident #4) sampled residents.

The findings included:

Medical record review for Resident #4 documented an admission date of 9/2/10 with diagnoses of End Stage Renal Disease, Atrial Fibrillation, Hypertension, and Arthritis. Review of the care plan dated 9/24/10.

2. Identification of others who could be affected by the deficient practice:
   This facility has no other dialysis patients at this time. No other residents were identified to have shunts and/or required emergency measures to stop bleeding.

3. Measures put in place to ensure deficient practice does not reoccur:
   The DON reviewed the care plan of resident #4 with the MDS nurses on 12/08/10 & changes were made. The MDS nurses were then re-educated by the DON that any new dialysis patients, or residents that have shunts, have care plans to include emergency measures to address bleeding.

4. Systems to monitor the effectiveness:
   The MDS nurses will be responsible for the completion & revision of care plans. The DON will review the care plans for completeness by the 7th day following the comprehensive assessment for any dialysis patients or residents that have shunts. Results of these reviews will be discussed with the QA Committee for recommendations during the monthly meeting. Members of the QA Committee: Administrator, DON, Medical Director, Ortho Medical Director, three ADONs, the Restorative Nurse, Staff Development Coordinator, Medical Records Clerk, Dietary Manager, Activity Director, Social Service Coordinator, Wound Care Nurse, MDS Coordinator, Housekeeping Director, Therapy Manager & Maintenance Director. Any non-

---

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 disclosed 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 disclosed 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction in sequence to continued program participation.
F 280  Continued From page 1
 documented, "...Observe shunt site for s/s [signs and symptoms] infection, pain, swelling, warmth or bleeding..." The care plan did not address measures to be put in place to stop emergency bleeding.

During an interview at the southeast nurses’ station on 12/8/10 at 9:30 AM, Nurse #9 stated, "...No [there are no measures to stop emergency bleeding documented on the care plan]..."

F 309  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 interview, it was determined the facility failed to follow physician orders for fluid restrictions or administer correct sliding scale insulin dosages for 5 of 24 (Residents #4, 10, 16, 17 and 21) sampled residents.

The findings included:

1. Medical record review for Resident #4 documented an admission date of 9/2/10 with diagnoses of End Stage Renal Disease, Atrial Fibrillation, Hypertension, and Arthropathy. Review of a Physician’s Telephone Order dated 11/29/10 documented, "...1500 ml [milliliters] fluid

F 280  compliance will be addressed by re-
education, further non-compliance will be addressed through disciplinary action per the progressive discipline protocol.

F 309  1. Corrective action for areas affected:

The ADON on resident #4’s unit initiated an Intake/Output sheet for him on 12/8/10 to monitor compliance with his fluid restriction. Resident #4 was discharged to home on 12/18/10 due to improved condition.

The nurses administering insulin to resident #10 on 11/03/10 & 11/15/10, as well as all licensed nursing staff who administer medications, were re-educated by the SDC (Staff Development Coordinator) as to proper insulin administration dosing by 12/15/10. The MD was notified of the concerns.

The nurses administering insulin to resident #16 on 11/24/10, 11/25/10 & 11/27/10, as well as all licensed nursing staff who administer medications, were re-educated by the SDC as to proper insulin administration dosing by 12/15/10. The MD was notified of the concerns.
| F 309 | Continued From page 2 restriction. The facility was unable to provide documentation of Resident #4's daily total fluid intake. During an interview at the southeast nurses' station on 12/9/10 at 9:30 AM, Nurse #9 stated, "I cannot find an I&O [intake and output] sheet for Resident #4." |
| F 309 | The nurses administering insulin to resident #17 on 10/28/10, 10/31/10 & 11/08/10, as well as all licensed nursing staff who administer medications, were re-educated by the SDC as to proper insulin administration dosing by 12/15/10. The MD was notified of the concerns. The nurse administering insulin to resident #21 on 12/02/10, 12/04/10 & 12/07/10, as well as all licensed nursing staff who administer medications, were re-educated by the SDC as to proper insulin administration dosing by 12/15/10. The MD was notified of the concerns. |

2. Medical record review for Resident #10 documented an admission date of 9/8/06 and a readmission date of 7/3/10 with diagnoses of Diabetes Mellitus Type II, Bipolar Disorder, Arterial Insufficiency, Anxiety, Depressive Disorder, Arthritis, Knee Amputation and Chronic Kidney Disease. Review of the physician's orders dated 11/3/10 documented, "...FBSS (finger stick blood sugar) AC (before meals) and HS [at bedtime] w/insulin/NOVOLOG INSULIN SLIDING SCALE AS FOLLOWS: 101 - 150 = [amount of insulin to be administered] 2U [units]; 151 - 200 = 4U..." Review of the November 2010 Medication Administration Record (MAR) documented the following:
   a. 11/3/10 - 7:30 AM, BS 117, 4 units of insulin administered instead of the ordered 2 units.
   b. 11/15/10 - 7:30 AM, BS 184, 6 units of insulin administered instead of the ordered 4 units.

During an interview at the south nurses' station on 12/7/10 at 10:00 AM, Nurse #7 reviewed Resident #10's November 2010 MAR and stated, "...Looks like she [Resident #10] got 4 units and should have gotten 2 units. Same thing on the blood sugar of 184. She got 6 and should have gotten 4." |

3. Medical record review for Resident #16 documented an admission date of 3/3/10 with...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID PREPFX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PROCESSED BY FULL REGULATORY OR LEG IDENTIFYING INFORMATION)</th>
</tr>
</thead>
</table>
| F 309         | Continued From page 3 diagnoses of Diabetes Mellitus, Congestive Heart Failure, Hypertension and Dementia. Review of the Physician’s orders dated 11/17/10 documented, "...Novolog SSI (sliding scale insulin) Subcutaneous (sq) Novolog SSI as follows...151-200 = 4 units...251-300 = 8 units..." Review of the November 2010 MAR documented the following:  
  a. 11/24/10 - 6:30 AM, Blood Sugar (BS) 156, 2 units of insulin administered instead of the ordered 4 units.  
  b. 11/25/10 - 4:30 PM, BS 266, 12 units of insulin administered instead of the ordered 8 units.  
  c. 11/27/10 - 6:30 AM, BS not obtained and no SSI administered.  
  4. Medical record review for Resident #17 documented an admission date of 11/17/10 with diagnoses of Diabetes Mellitus Type II, Congestive Heart Failure, Benign Prostate Hypertrophy, Depression, Neuropathy and Morbid Obesity. Review of the physician’s orders dated 11/3/10 documented, "...Novolog R with SSI SQ before meals and at bedtime...201-250=8 units, 251-300=12 units..." Review of the October 2010 MAR documented the following:  
  a. 10/28/10 - 11:30 AM, BS 272, 8 units of insulin was administered instead of the ordered 4 units.  
  b. 10/31/10 - 11:30 AM, BS 233, there was no documentation the ordered 8 units of SSI was administered.  
  Review of the November 2010 MAR documented 11/8/10 - 9:00 PM, BS 227. There was no documentation that the ordered 8 units of SSI was administered.  
  During an interview at the southeast nurse’s station on 12/7/11 at 3:30 PM, Nurse #3

<table>
<thead>
<tr>
<th>ID PREPFX TAG</th>
<th>PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
</table>
| F 309         | Compliance of MD orders by 12/22/10. Any new licensed nursing staff will be educated on this during orientation process.  
  All licensed nursing staff that administers medications were re-educated by the SDC as to “Following MD Orders” & proper insulin administration dosing by 12/15/10. Any new licensed nursing staff will be educated on this during orientation process.  
  Licensed nursing staff that administer medications & record Intake/Outputs on residents with fluid restrictions were instructed by the ADONs on 12/22/10 as to shift-to-shift checks of insulin administration & Intake/Output documentation for the previous shift during shift change. Any new licensed nursing staff will be educated on this during orientation process. Shift-to-Shift log sheets were initiated on 12/23/10 as a means to document this check was done. Licensed nurses are responsible for proper insulin administration/documentation, Intake/Output documentation of residents with fluid restrictions & shift-to-shift review of same.  
  4. This corrective action will be monitored by:  
  The ADON of each unit will spot check 10% of the insulin administration Documentation & 100% of the Intake/Output documentation on residents with fluid restrictions weekly for proper
<p>| F 309 | Continued From page 4 confirmed that Resident #17 did not receive the SSI as ordered. 5. Medical record review for Resident #21 documented an admission date of 11/27/10 with diagnoses of Diabetes Mellitus, Peripheral Neuropathy, Peripheral Vascular Disease, Chronic Kidney Disease, Pressure Sores, and Hypothyroidism. Review of the physician's orders dated 11/2/10 documented, &quot;...Novolog insulin as follows... 111-150=on [to] insulin...&quot; Review of the December 2010 MAR documented the following: a. 12/2/10 - 7:30 AM, BS 148, 2 units of insulin administered instead of 0 as ordered. b. 12/2/10 - 11:30 AM, BS 129, 2 units of insulin administered instead of 0 as ordered. c. 12/4/10 - 7:30 AM, BS 122, 2 units of insulin administered instead of 0 as ordered. d. 12/7/10 - 11:30 AM, BS 141, 2 units of insulin administered instead of 0 as ordered. During an interview at the north nurses' station on 12/8/10 at 8:20 AM, Nurse #9 reviewed the December 2010 MAR and confirmed that Resident #21 did not receive the SSI as ordered on the dates noted above. insulin administration/documentation, Intake/Output documentation &amp; shift-to-shift review of same. The results of these checks will be reported monthly to the QA Committee for review &amp; recommendations to ensure compliance. Members of the QA Committee: Administrator, DON, Medical Director, Ortho Medical Director, three ADOs, the Restorative Nurse, Staff Development Coordinator, Medical Records Clerk, Dietary Manager, Activity Director, Social Service Coordinator, Wound Care Nurse, MDS Coordinator, Housekeeping Director, Therapy Manager &amp; Maintenance Director. |
| F 332 | SS=D 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 review of the &quot;MED-PASS COMMON INSULIN&quot; provided by the American Society of Consultant Pharmacist, medical record review, | F 332 | SS=D 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 review of the &quot;MED-PASS COMMON INSULIN&quot; provided by the American Society of Consultant Pharmacist, medical record review, |</p>
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECISED BY FULL REGULATORY OR 150 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>
</thead>
<tbody>
<tr>
<td>F 332</td>
<td>Continued From page 5 observation and interview, it was determined the facility failed to ensure 2 of 5 nurses (Nurses #1 and 3) administered medications with a medication error rate of less than 5 percent (%). A total of 5 medications errors were observed out of 40 opportunities for error, resulting in a medication error rate of 12.5%. The findings included: 1. Review of the &quot;MED-PASS COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties&quot; provided by the American Society of Consultant Pharmacist for typical dosing administration of insulin related to meals documented, &quot;...Novolog... ONSET (in hours unless noted)... 15 min [minutes]... TYPICAL DOSING / COMMENTS... 5-10 minutes before meals...&quot; Review of the &quot;MED-PASS COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties&quot; provided by the American Society of Consultant Pharmacist for typical dosing administration of insulin related to meals documented, &quot;...Novolin 70/30... ONSET (in hours unless noted)... 30 min [minutes]... TYPICAL DOSING / COMMENTS... give approximately 15 minutes before meal...&quot; 2. Medical record review for Resident #10 documented an admission date of 3/8/10 with diagnoses of Chronic Airway Obstruction, Hypertension, Diabetes Mellitus, Cardia Pacemaker. Review of a physician's order dated 7/30/10 documented, &quot;FSBS [Finger Stick Blood Sugar] (accucheck) AC [before meals] and HS [hour of sleep] w/ [with] / NOVOLOG INSULIN SLIDING SCALE AS FOLLOWS: 10-150 [amount of insulin to be administered] 2U [units]...</td>
<td>F 392</td>
<td>The insulin orders have been reviewed &amp; clarified to provide proper administration in proximity of mealtime. The nurse administering insulin to resident #16 on 12/07/10, as well as all licensed nursing staff who administer medications, were re-educated by the SDC as to proper insulin administration timing &amp; dosing by 12/15/10. The MD was notified of the concerns. The insulin orders have been reviewed &amp; clarified to provide proper administration in proximity of mealtime. The charge nurse notified the MD of the concern &amp; clarified the Flosine order for RR #1 on 12/07/10 to read &quot;50 mcg&quot;. After 12/07/10 Miralax for RR #1 was given with 8 oz liquid per MD order until the order was changed on 12/16/10 to read, &quot;give with 4-8 oz of liquid&quot;. 2. Identification of others areas that could be affected by the deficient practice: On 12/20/10 the ADON of each unit reviewed the insulin administration documentation on his/her unit since the 12/15/10 re-education was completed. No discrepancies were found. The insulin orders have been reviewed &amp; clarified to provide proper administration in proximity of mealtime. The DON reviewed all other Flosine orders of current residents on 12/07/10 &amp; no discrepancies were noted.</td>
<td>12/06/2010</td>
</tr>
</tbody>
</table>
**F 332**  
Continued From page 8

NOVOCIN 70/30, 20 units Subcutaneous (sq) Q [every] PM 1630 [4:30].

Observations in Resident #19’s room on 12/6/10 beginning at 4:25 PM, Nurse #1 administered 2 units of Novolog insulin and 20 units of Novolin 70/30 to Resident #10. Resident #10 did not receive her meal tray until 6:49 PM. The administration of insulin 1 hour and 24 minutes before dinner was served resulted in medication errors #1 and #2.

3. Medical record review for Resident #16 documented an admission date of 3/3/10 with a readmission date of 4/19/10 with diagnoses of Diabetes Mellitus, Dementia, Congestive Heart Failure and Hypertension. Review of a physician’s order dated 11/19/10 documented, “NOVOCLOG SS1 (sliding scale insulin) Subcutaneous (sq) ...251-300+ 8 units...”

Observations in Resident #16’s room on 12/7/10 beginning at 11:38 AM, Nurse #3 administered 8 units of Novolog insulin to Resident #16. Resident #16 did not receive his lunch tray until 12:14 PM. The administration of the insulin 36 minutes before lunch was served resulted in medication error #3.


---

**F 332**

By 12/16/10 the ADON on each unit had reviewed & clarified with the MD all Miralax orders of his/her residents.

3. Measures put in place to ensure deficient practice does not recur:  
All licensed nursing staff that administers medications were re-educated by the SDC as to “Following MD Orders” & proper insulin administration timing & dosing by 12/15/10. Any new licensed nursing staff will be educated on this during orientation process.

Licensed nursing staff that administer medications & record Intake/Outputs were instructed by the ADONs on 12/22/10 as to shift-to-shift checks of insulin administration & Intake/Output documentation on resident with fluid restriction for the previous shift during shift change. Any new licensed nursing staff will be educated on this during orientation process. Shift-To-Shift logs sheets were initialed on 12/23/10 as a means to document this check was done.

Licensed nurses are responsible for proper insulin administration/documentation, Intake/Output documentation & shift-to-shift review of same.

The ADON of each unit will bring all new physicians’ orders to the morning clinical meeting for discussion & review. Any orders that need clarification will be identified at that time. The ADON will be responsible for obtaining the clarification.
**F 332** Continued from page 7

1 spray each nostril daily...

Observations in RR #1's room on 12/7/10 at 8:25 AM, Nurse #3 administered Flonase 50 mcg spray in each of RR #1's to each nostril and administered Miralax powder 17 gm in 4 ounces of water. The administration of the incorrect dosage of the medication Flonase resulted in medication error #4 and the administration of Miralax in 4 ounces of water resulted in medication error #5.

During an interview at the southeast nurses' station on 12/7/10 at 2:30 PM, Nurse #3 stated, "It is 50 [50 mcg dosage administered instead of the ordered 25 mcg]."

During an interview at the southeast nurses' station on 12/7/10 at 2:30 PM, Nurse #3 stated, "It's 8 [8 oz of water instead of the ordered 4 oz]."

**F 333** 

SS = D

**333**

The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:

Based on review of "MED-PASS COMMON INSULINS" provided by the American Society of Consultant Pharmacist, medical record review, observations and interviews, it was determined the facility failed to ensure that residents were free of significant medication errors when 3 of 5 nurses (Nurses #1, 2 and 3) failed to ensure insulin administration was correlated with meals.

The findings included:

**F 332** of any orders identified, including insulin administration times.

4. This corrective action will be monitored by:

The ADON of each unit will spot check 10% of the insulin administration documentation & 100% of the Intake/Output documentation of residents on fluid restrictions weekly for proper insulin administration/documentation, Intake/Output documentation & shift-to-shift review of same.

The DON will monitor for clarifications done by reviewing the new orders during the morning clinical meeting the day after a need for clarification was identified.

The results will be reported monthly to the QA Committee for review & recommendations to assure compliance.

Members of the QA Committee:

- Administrator, DON, Medical Director,
- Ortho Medical Director, three ADONs, the Restorative Nurse, Staff Development Coordinator, Medical Records Clerk, Dietary Manager, Activity Director, Social Service Coordinator, Wound Care Nurse, MDS Coordinator, Housekeeping Director, Therapy Manager & Maintenance Director.

**F 333**

1. Corrective action for areas affected:

The nurse administering insulin to resident #10 on 12/06/10, as well as all licensed nursing staff who administer medications, were re-educated by the SDC (Staff Development Coordinator) as to proper insulin administration timing & dosing by...
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LIC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPLICABLE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 333</td>
<td>Continued From page 6</td>
<td>1. Review of the &quot;MED-PASS COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties&quot; provided by the American Society of Consultant Pharmacist for typical dosing administration of insulin related to meals documented, &quot;...Novolog...ONSET (in hours unless noted)...15 min [minutes]... TYPICAL DOsing / COMMENTS...5- [to] 10 minutes before meals...&quot;</td>
<td>12/15/10. The MD was notified of the concern. The insulin orders have been reviewed &amp; clarified to provide proper administration in proximity of mealtime. The nurses administering insulin to resident #16 on 12/07/10, as well as all licensed nursing staff who administer medications, were re-educated by the SDC as to proper insulin administration timing &amp; dosing by 12/15/10. The MD was notified of the concern. The insulin orders have been reviewed &amp; clarified to provide proper administration in proximity of mealtime.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Review of the &quot;MED-PASS COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties&quot; provided by the American Society of Consultant Pharmacist for typical dosing administration of insulin related to meals documented, &quot;...Novolin 70/30...ONSET [in hours unless noted]...30 min [minutes]... TYPICAL DOsing / COMMENTS...give approximately 30 minutes before meal...&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Observations in Resident #10's room on 12/6/10 beginning at 4:25 PM, Nurse #1 administered 2 units of Novolog insulin and 20 units of Novolin 70/30 insulin to Resident #10. Resident #10 did not receive her meal tray until 5:49 PM. The administration of the Novolog insulin as well as</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
F 333 Continued From page 9
the Novolin 70/30 insulin 1 hour and 24 minutes before dinner was served resulted in significant medication errors.

3. Medical record review for Resident #16 documented an admission date of 3/3/10 with a readmission date of 4/19/10 with diagnoses of Diabetes Mellitus, Dementia, Congestive Heart Failure and Hypertension. Review of a physician's order dated 11/18/10 documented, "NOVOLOG SSI [sliding scale insulin] Subcutaneous (sq) ...251-300= 8 units..."

During an interview on the southeast hall on 12/7/10 at 6:05 AM, Nurse #2 was asked if Resident #16 was to get any insulin. Nurse #2 stated, "I gave him [Resident #16] his insulin at about 5:45 [AM]."

Observations on the southeast hall on 12/7/10 revealed Resident #16 did not receive his breakfast tray until 7:38 AM. The failure to ensure that Resident #16 received a meal tray within 5 to 10 minutes of Novolog insulin administration resulted in a significant medication error.

Observations in Resident's #16's room on 12/7/10 beginning at 11:38 AM, Nurse #3 administered 8 units of Novolog insulin to Resident #16. Resident #16 did not receive his lunch tray until 12:14 PM. The administration of Resident #16's insulin 36 minutes before the lunch meal was served resulted in a significant medication error.

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 will be educated on this during orientation process.Licensed nursing staff that administer medications & record Intake/Output were instructed by the ADONs on 12/22/10 as to shift-to-shift checks of insulin administration documentation for the previous shift during shift change. Any new licensed nursing staff will be educated on this during orientation process. Shift-to-Shift log sheets were initialed 12/23/10 as a means to document this check was done. Licensed nurses are responsible for proper insulin administration/documentation & shift-to-shift review of same.

The ADON of each unit will bring all new physician's orders to the morning clinical meeting for discussion & review. Any orders that need clarification will be identified at that time. The ADON will be responsible or obtaining the clarification of any orders identified, including insulin administration times.

4. This corrective action will be monitored by:
The ADON of each unit will spot check 10% of the insulin administration documentation weekly for proper insulin administration/documentation & shift-to-shift review of same.

The DON will monitor for clarifications done by reviewing the new orders during the morning clinical meeting the day after a need for clarification was identified.

The results will be reported monthly to the QA Committee for review &
F 333 Continued From page 9
the Novolin 70/30 insulin 1 hour and 24 minutes

before dinner was served resulted in significant
medication errors.

3. Medical record review for Resident #16
documented an admission date of 3/3/10 with a
readmission date of 4/19/10 with diagnoses of
Diabetes Mellitus, Dementia, Congestive Heart
Failure and Hypertension. Review of a physician's
order dated 11/18/10 documented, "NOVOLOG
SSI (sliding scale insulin) Subcutaneous (sq)
...251-300 = 8 units..."

During an interview on the southeast hall on
12/7/10 at 6:05 AM, Nurse #2 was asked if
Resident #16 was to get any insulin. Nurse #2
stated, "I gave him [Resident #16] his insulin at
about 5:45 AM."

Observations on the southeast hall on 12/7/10
revealed Resident #16 did not receive his
breakfast tray until 7:38 AM. The failure to ensure
that Resident #16 received a meal tray within 5 to
10 minutes of Novolog insulin administration
resulted in a significant medication error.

F 441

Observations in Residents #16's room on 12/7/10
beginning at 11:38 AM, Nurse #3 administered 8
units of Novolog insulin to Resident #16. Resident
#16 did not receive his lunch tray until 12:14 PM.
The administration of Resident #16's insulin 36
minutes before the lunch meal was served
resulted in a significant medication error.

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

recommends to ensure compliance.

Members of the QA Committee:
Administrator, DON, Medical Director,
Ortho Medical Director, three ADONs, the
Restorative Nurse, Staff Development
Coordinator, Medical Records Clerk,
Dietary Manager, Activity Director, Social
Service Coordinator, Wound Care Nurse,
MDS Coordinator, Housekeeping
Director, Therapy Manager &
Maintenance Director.

1. Corrective action for areas affected:
The SDC had re-educated CNA #1,
2,3,4,5,6,7,8,9,10,11 & nurse #8, as well as
all other CNAs & licensed nurses, on
proper hand washing techniques & hand
washing guidelines with food handling by
12/22/10.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID</th>
<th>PROVIDER/SUPPLIER ID</th>
<th>IDENTIFICATION NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 441</td>
<td>445465</td>
<td></td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

**SIGNATURE HEALTHCARE OF COLUMBIA**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1410 TROTWOOD AVENUE

COLUMBIA, TN 38401

**DATE SURVEY COMPLETED**

12/08/2010

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 441</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECISELY DESCRIBED IN FULL, INCLUDING THE INDICATING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continued from page 10 to help prevent the development and transmission of disease and infection.</td>
</tr>
</tbody>
</table>

(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 review, observations and interviews, it was determined the facility failed to ensure practices to prevent the potential spread.

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 441</td>
<td></td>
</tr>
</tbody>
</table>

2. Identification of others areas that could be affected by the deficient practices:

- All residents who receive meal trays have the potential to be affected.

3. Measures put in place to ensure deficient practices do not recur:

- The SDC had re-educated CNA #1, 2,3,4,5,6,7,8,9,10, 11 & nurse #8, as well as all other CNAs & licensed nurses, on proper hand washing technique and hand washing guidelines with food handling by 12/22/10. The direct care staff is responsible for proper hand washing during tray service. Any new nursing staff will be educated on this during orientation process.

4. This corrective action will be monitored by:

- The ADON of each unit will monitor for compliance on his/her unit through spot checks of hand washing technique and frequency during tray service. These spot checks will occur twice weekly at random times of day. The results of these spot checks will be reported monthly to the QA Committee for review & recommendations to ensure compliance. Members of the QA Committee: Administrator, DON, Medical Director, Ortho Medical Director, three ADONs, the Restorative Nurse, Staff Development Coordinator, Medical Records Clerk, Dietary Manager, Activity Director, Social Service Coordinator, Wound Care Nurse, MDS Coordinator, Housekeeping Director, Therapy Manager & Maintenance Director.

**OIC NO. 0938-0391**

**FORM APPROVED**

**Printed: 12/13/2010**

**Facility ID: TN0008**

If continuation sheet Page 11 of
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES**

<table>
<thead>
<tr>
<th>DATE PLAN OF CORRECTION COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/09/2010</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

**SIGNATURE HEALTHCARE OF COLUMBIA**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1410 TROTWOOD AVENUE

COLUMBIA, TN 32491

**ID PREFIX**

**TAG**

<table>
<thead>
<tr>
<th>FAMILY NAME</th>
<th>ID NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>445465</td>
</tr>
</tbody>
</table>

**SUMMARY STATEMENT OF DEFICIENCIES**

(Each deficiency must be preceded by full regulatory or USC identifying information)

<table>
<thead>
<tr>
<th>ID</th>
<th>NAME OF DEFICIENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>F441</td>
<td>Continued From page 11</td>
</tr>
</tbody>
</table>

- of infection were maintained when 12 of 16 staff members (Certified Nursing Assistants (CNA) #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 and Nurse #8) failed to practice sanitary hand hygiene, touched straws with their bare hands or placed a contaminated tray back on the cart with unserved meals trays during dining.

The findings included:

1. Review of the facility’s "Handwashing/Hand Hygiene" policy documented, [Wash hands] ...5a. Before and after direct contact with residents... 5d. After removing gloves... 5a. Before and after direct contact with residents... l. after contact with objects (...medical equipment) in the immediate vicinity of the resident... 6j. After removing gloves..."

2. Observations in room 85 on 12/7/10 at 7:25 AM, CNA #1 applied gloves and helped reposition a resident in bed. CNA #1 then removed her gloves and proceeded to serve and set up a meal tray for another resident without washing her hands.

3. Observations in room 62A on 12/7/10 at 8:25 AM, CNA #2 adjusted the bed with the crank, repositioned the resident and then began to set up the tray without washing her hands.

4. Observations in room 44 on 12/7/10 at 8:40 AM, CNA #3 placed the breakfast meal tray on the resident's overbed table and set up the meal. CNA #3 stated, "This is the wrong tray. It is for another resident." CNA #3 removed the tray from the room and placed it back in the meal cart with two (2) other trays that had not been served. The two other trays were later served to the other...
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>F 441</th>
<th>F 441</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUMMARY STATEMENT OF DEFICIENCIES</td>
<td>Continued From page 12 residents.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>During an interview in the conference room on 12/8/10 at 9:10 AM, the Director of Nursing (DON) was asked what is expected during meal tray pass when the wrong tray is set up for a resident. The DON stated, &quot;...take the tray cut and put it [tray] in an empty meal cart. They [staff] should not put it [a served tray] in a cart with clean trays that have not been served.&quot;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Observations in room 35A on 12/6/10 at 5:40 PM, CNA #4 did not wash her hands prior to tray delivery or preparation of the tray. CNA #4 touched the sandwich with her bare hand, held the sandwich with one hand while using a knife to cut the sandwich in half. CNA #4 opened the straw and touched the straw with her bare hand, picked up the corn bread and held the corn bread in the palm of her bare while buttering the corn bread with a knife.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Observations in room 24 on 12/6/10 at 5:45 PM, CNA #5 touched the crank on the bed, moved the wheelchair and set up the meal tray. CNA #5 placed her bare finger in the milk carton to open the carton milk and opened the straw touching the straw with her bare hand. CNA #6 left the resident's room and did not wash hands prior to obtaining another meal tray off the cart for the next resident. CNA #6 served the next resident's tray without washing her hands.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Observations in room 36A on 12/6/10 at 5:55 PM, revealed CNA #5 adjusted the bed with the crank then began to set up the tray. CNA #5 touched the bread with her bare hand, opened the straw and touched the straw with her bare hand. CNA #5 began to feed the resident without washing her</td>
<td></td>
</tr>
<tr>
<td>ID TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRICED BY FULL REGULATORY OR LIC IDENTIFYING INFORMATION)</td>
<td>ID TAG</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
</tbody>
</table>
| F 441  | Continued From page 13 hands.  
7. Observations in room 1B on 12/7/10 at 7:15 AM, CNA #6 did not wash her hands prior to tray delivery or preparation of the tray. CNA #6 opened the straw and touched the straw with her bare hand.  
8. Observations in room 38A on 12/7/10 at 7:35 AM, CNA #7 opened the straw and touched the straw with her bare hand.  
9. Observations in room 18 on 12/7/10 at 7:40 AM, CNA #8 opened the straw and touched the straw with her bare hand.  
10. Observations in room 15 on 12/7/10 at 7:55 AM, CNA #9 opened the straw and touched the straw with her bare hand.  
11. Observations in room 11A on 12/7/10 at 8:00 AM, CNA #10 opened the straw and touched the straw with her bare hand.  
12. Observations in room 11B on 12/7/10 at 8:05 AM, CNA #11 adjusted the bed with the crank and then began to set up the meal tray. CNA #11 peeled the banana and then touched the banana with her bare hand, opened the straw and touched the straw with her bare hand.  
13. Observations in room 36B on 12/8/10 at 5:55 PM, Nurse #8 opened the straw and touched the straw with her bare hand.  
14. During an interview in the conference room on 12/6/10 at 9:15 AM, the Director of Nursing (DON) was asked what is the expectation of staff when passing meal trays. The DON stated, | F 441  |                                                                                     |                 |                                                                                     |                 |
F 441 Continued from page 14
"...staff is to wash hands if touched a resident, don't touch food with bare hand... When take gloves off hands are to be washed..."

F 465 482.70(h)
SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:
Based on observations and interviews, it was determined the facility failed to ensure the environment was clean and sanitary as evidenced by a brown substance on the shower bench, a black substance on the lid of the shower chair, small pile of green/brown substance on the floor tile and a small light brown substance on the floor tile in the shower stall in 4 of 7 (North #2, North #3, South #2 and South #3 shower rooms) shower rooms.

The findings included:

1. Observations in the North shower #2 on 12/6/10 at 11:10 AM and 2:10 PM, on 12/7/10 at 11:20 AM and on 12/8/10 at 7:35 AM, revealed a brown substance on the shower bench.

During an interview in the North shower #2 on 12/8/10 at 9:20 AM, the Director of Nurses (DON) was asked what the brown substance was on the shower bench. The DON stated, "I got an idea of what that is, don't know exactly. I will get someone to clean it."

F 441
F 465

F465
1. Corrective action for areas affected:
   1) The DON immediately following this observation cleaned the shower bench in North shower #2 on 12/8/10.
   2) The Housekeeping Supervisor immediately following this observation cleaned the shower chair in North shower #3 on 12/8/10.
   3) The floor of South shower room #2 had been cleaned prior to the 12/8/10 interview of the DON.
   4) The floor of South shower room #3 was cleaned 12/8/10 immediately following the observation.

2. Identification of other areas that could be affected by the deficient practice:
The Housekeeping Supervisor checked all other shower rooms for cleaning needs on 12/8/10. No other problems were identified.

3. Measures put in place to ensure deficient practice does not recur:
The Housekeeping Staff was re-educated by the Housekeeping Supervisor on 12/13/10 as to the shower room cleaning duties & expectations. The routine will include a spot check at the beginning of the shift by the housekeeper assigned to that hall. Any obvious cleaning needs will be immediately addressed. The shower
**F 465** Continued From page 15

2. Observations in the North shower #3 on 12/8/10 at 2:50 PM, on 12/7/10 at 11:28 AM and on 12/8/10 at 8:05 AM, revealed a black substance on the lid of the shower chair.

During an interview in the North shower #3 on 12/8/10 at 8:20 AM, the DON was asked what that black substance was on the lid of the shower chair. The DON stated, "it looked like someone placed a wet shoe on there, I will get someone to clean it."

3. Observations in the South shower #2 on 12/7/10 at 10:40 AM, revealed a small pile of green/brown substance on the floor tile.

4. Observations in the South shower #3 on 12/8/10 at 8:12 AM, revealed a small light brown substance on the floor tile.

During an interview in South shower #3 on 12/8/10 at 8:15 AM, the DON and the Assistant Director of Nurses were asked what was the brown substance on the floor tile. The DON stated, "I don’t know what that is, will get housekeeping to come and clean up the floor."

---

**F 508**

<table>
<thead>
<tr>
<th>SS-D</th>
<th>PROVIDE/OBTAIN RADIOLGY/DIAGNOSTIC SVCS</th>
</tr>
</thead>
</table>

The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to ensure that...

---

**F 508**

1. Corrective action for areas affected:

   The ADON for resident #13 notified the MD of the missing x-ray & an order was received to do the original order to obtain the x-ray.

---

**F 465**

rooms will then be cleaned mid-morning & again near end of shift. All new staff will be educated to this procedure during orientation.

4. Systems to monitor the effectiveness:

   A work sheet was implemented to provide documentation of these checks & cleanings that will be initiated by the housekeeper performing the work. The Housekeeping Supervisor will spot check all shower rooms for cleanliness & documentation for completion twice weekly.

Results of these checks will be presented to the QA Committee monthly for review and recommendations. Members of the QA Committee: Administrator, DON, Medical Director, Ortho Medical Director, three ADONs, the Restorative Nurse, Staff Development Coordinator, Medical Records Clerk, Dietary Manager, Activity Director, Social Service Coordinator, Wound Care Nurse, MDS Coordinator, Housekeeping Director, Therapy Manager & Maintenance Director.

---

**F 508**

<table>
<thead>
<tr>
<th>SS-D</th>
<th>PROVIDE/OBTAIN RADIOLGY/DIAGNOSTIC SVCS</th>
</tr>
</thead>
</table>

The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to ensure that...

---

**F 508**

1. Corrective action for areas affected:

   The ADON for resident #13 notified the MD of the missing x-ray & an order was received to do the original order to obtain the x-ray.

---
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CODED REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 508</td>
<td></td>
<td>Continued From page 16 diagnostic services were completed as ordered by the physician for 1 of 24 (Resident #13) sampled residents. The findings included: Medical record review for Resident #13 documented an admission date of 8/26/10 with diagnoses of Pathologic Fracture Vertebrae, Unspecified Disorder Bone and Cartilage, Hypotension, Unspecified Protein-Calorie Malnutrition, Psychosis, Depression/Angina. Review of a physician’s order dated 10/8/10 documented, “...portable CXR (chest x-ray)...” The facility unable to provide documentation that the CXR had been done as ordered. During an interview at the North nurses’ station on 12/7/10 at 11:50 AM, Nurse #8 stated, “No chest x-ray results on chart. I phoned the hospital and the mobile unit and [the chest x-ray was] not done...”</td>
<td>F 508</td>
<td></td>
<td>2. Identification of areas of others that could be affected by the deficient practice: The ADON for each unit reviewed the current resident orders on his/her unit &amp; found no x-ray orders that had not been completed. 3. Measures put in place to ensure deficient practice does not recur: The nurses were instructed on 12/21/10 by the ADON of each unit to enter the pending x-ray orders into the current “Lab Book” for follow-through in the same manner the lab orders are tracked. Any new licensed nursing staff will be educated on this during orientation process. The x-ray order will be entered into the book when received &amp; a notation made when the x-ray is completed. A second notation is made when the results are received. 4. This corrective action will be monitored by: The ADON of each unit will continue to check the “Lab Book” every morning as part of their routine monitoring. All x-ray results will be discussed at morning clinical meeting with the DON. The results of these reviews will be reported monthly to the QA Committee for review &amp; recommendations to ensure compliance. Members of the QA Committee: Administrator, DON, Medical Director, Ortho Medical Director, three ADONs, the Restorative Nurse, Staff</td>
</tr>
<tr>
<td>ID PREFIX</td>
<td>TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID PREFIX</td>
<td>TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</td>
</tr>
<tr>
<td>-----------</td>
<td>-----</td>
<td>---------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-----</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>F 50B</td>
<td></td>
<td>Continued From page 18 diagnostic services were completed as ordered by the physician for 1 of 24 (Resident #13) sampled residents.</td>
<td>F 50B</td>
<td></td>
<td>Development Coordinator, Medical Records Clerk, Dietary Manager, Activity Director, Social Service Coordinator, Wound Care Nurse, MDS Coordinator, Housekeeping Director, Therapy Manager &amp; Maintenance Director.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The findings included:</td>
<td></td>
<td></td>
<td>Medical record review for Resident #13 documented an admission date of 8/26/10 with diagnoses of Pathologic Fracture Vertebrae, Unspecified Disorder Bone and Cartilage, Hyponatremia, Unspecified Protein-Calorie Malnutrition, Psychosis, Depression/Anxiety. Review of a physician's order dated 10/8/10 documented, &quot;...portable CXR [chest x-ray]...&quot; The facility was unable to provide documentation that the CXR had been done as ordered.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>During an interview at the North nurses' station on 12/7/10 at 11:50 AM, Nurse #6 stated, &quot;No chest x-ray results on chart. I phoned the hospital and the mobile unit and [the chest x-ray was not done]...&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>