F 164 SS-E

483.10(e), 483.75(i)(4) PRIVACY AND CONFIDENTIALITY

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephonic communications, personal care, visits, and meetings of family and resident groups, but does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident’s right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident’s records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:

Based on policy review, observations and interviews, it was determined the facility staff failed to maintain residents’ privacy by failing to knock on residents’ doors prior to entering or gaining permission to enter the room on 3 of 4 (100, 200 and 400 hallways) resident hallways.

1. Immediate Intervention:
   No specific residents were identified in this citation. The Social Services Director or Director of Nursing will request comments regarding privacy being provided by knocking on resident’s doors, announcing themselves, and allowing the resident time to respond prior to entering their rooms.

2. Identification of the residents with potential to be affected:
   All residents have the potential to be affected.

3. Measures to prevent reoccurrence:
   Staff will receive in-service education provided by the Staff Development Coordinator or designee by 4/23/09 regarding knocking on resident’s doors, announcing themselves, and allowing the resident to respond prior to entering the resident’s room. The Social Services Director will interview four alert and oriented residents weekly for four weeks to ensure that staff are providing privacy by following the guidelines as taught in the in-service. The Social Services Director or Director of Nursing will request comments regarding privacy being provided by knocking on resident’s doors, announcing themselves, and allowing the resident time to respond prior to entering their rooms, in the Resident Council Meeting monthly for 3 months.

Administrator 4-10-09

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 disclosable 50 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 164 Continued From page 1

The findings included:

1. Review of the facility's "Basic Nursing Policy & [and] Procedure Manual Morning Care" documented, "...2. Knock on resident's door before entering..."

2. Observations in the 100 hallway on 3/23/09 at 7:32 AM, revealed Certified Nursing Assistant (CNA) #1 entered room 108 to deliver a breakfast tray. CNA #1 did not knock on the door prior to entering the resident's room.

3. Observations in the 100 hallway on 3/23/09 at 7:34 AM, revealed CNA #2 entered room 107 to deliver a breakfast tray. CNA #2 did not knock on the door prior to entering the resident's room.

4. During a resident interview inside room 206 on 3/24/09 at 1:00 PM, the surveyor asked Resident #19 if he felt the staff honored his privacy and knocked on his door before entering his room. Resident #19 stated, "If they knock at all, it is when they have done got in your room... Sometimes they knock as they are walking on in..."

5. Observations during the medication administration pass on the 200 hallway on 3/23/09 at 8:02 AM and 8:33 AM, revealed Licensed Practical Nurse (LPN) #3 entered room 214 to administer medication to a resident. LPN #3 did not knock before entering the resident's room.

6. Observations in room 405 on 3/24/09 at 9:30 AM, CNA #3 walked into the room knocking as she entered without giving the resident a chance
Continued From page 2

to invite her in. The resident stated, "It was good I had my clothes on...Techs [technicians] do this [enter without knocking] quite often."

7. The group interview was conducted in the Activity Room on 3/23/09 at 2:00 PM, with eight residents that the facility had identified as being alert and oriented. Four of the 8 alert and oriented residents stated that staff knock while entering their rooms and they are not allowed to answer prior to them entering.

F 174
483.10(k) TELEPHONE
SS=D

The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

This REQUIREMENT is not met as evidenced by:
Based on the group interview and a staff member interview, it was determined the facility failed to provide telephone access where conversations could not be overheard for 2 of 8 alert and oriented residents attending the group meeting.

The findings included:

The group interview was conducted in the Activity Room on 3/23/09 at 2:00 PM, with eight residents that the facility had identified as being alert and oriented. Two of the 8 alert and oriented residents stated that they used the telephone at the nurses' desk to make private phone calls. Both residents stated their phone conversations were not always private.

During an interview in the Administrator's office on 3/24/09 at 3:00 PM, the Administrator verified

1. **Immediate Intervention:**
   - No specific residents were identified in this citation.

2. **Identification of the residents with potential to be affected:**
   - All residents have the potential to be affected by not having a private telephone for private use.

3. **Measures to prevent reoccurrence:**
   - A cordless telephone will be installed in the facility for resident usage by 4/23/09. The phone will be available in the Golden Oak dining room.
   - Staff will receive in-service education regarding the cordless phone for resident usage and assisting the resident to a private area as needed, provided by the Director of Nursing or designee 4/23/09. The Social Services Director will interview four alert and oriented residents weekly for four weeks to ensure they are aware of the cordless phone and have received the appropriate assistance in utilizing the phone in a private area.
F 174
Continued From page 3
the residents use the phone at the nurses' station. The administrator stated that the facility did not have a designated privacy phone for residents to use.

F 280
483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS

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 to reflect the resident's current status for emergency bleeding for 2 of 23 (Residents #3 and 16) sampled residents.

The findings included:

F 174
4. Monitoring:
Findings of the interviews with residents will be presented to the Quality Assurance Committee monthly for 3 months for recommendations and follow-up.

F 280
1. Immediate Intervention:
Care plans were revised by the MDS Coordinator on 4/9/09 for both residents in the facility requiring dialysis. Interventions were added to address specific actions if bleeding did occur.

2. Identification of the residents with potential to be affected:
No other residents in the facility require dialysis at this time. Interventions will be included on the immediate care plan for newly admitted residents requiring dialysis regarding the status for bleeding.
**NAME OF PROVIDER OR SUPPLIER**

MONTGOMERY CARE AND REHABILITATION CENTER

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

198 OLD FARMER ROAD
CLARKSVILLE, TN 37043

<table>
<thead>
<tr>
<th>ID</th>
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<th>COMPLETION DATE</th>
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<tr>
<td>F 280</td>
<td>3. Measures to prevent recurrence: Nursing staff will receive in-service education provided by the Staff Development Coordinator or designee by 4/23/09 regarding revised care plan interventions for dialysis residents for the potential for bleeding, and to ensure that interventions are added to the immediate care plan to address the potential for bleeding for newly admitted residents requiring dialysis. The MDS Coordinator will review the care plans of residents requiring dialysis to ensure that care plan interventions are in place regarding the current status for bleeding.</td>
<td>3/24/2009</td>
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<tr>
<td>F 280</td>
<td>Continued From page 4 1. Medical record review for Resident #3 documented an admission date of 1/19/07 with diagnoses of Chest Pain, Diabetes, Weakness, Dyspnea and General Anxiety. Review of the plan of care updated 2/10/09 documented Resident #3 received dialysis and &quot;Observe for excessive bleeding and notify MD [medical doctor] if unable to stop bleeding.&quot; The care plan did not address measures to be put in place to stop emergency bleeding. 2. Medical record review for Resident #16 documented an admission date of 12/1/05 with diagnoses of Renal Failure, Malaise, Muscle weakness, Diabetes, Hypertension, Cataracts and Heart Disease. Review of the plan of care updated 1/29/09 documented Resident #16 received dialysis and &quot;Monitor for excessive bleeding and notify MD if unable to stop bleeding.&quot; The care plan did not address measures to be put in place to stop emergency bleeding. 3. During an interview in the conference room on 3/24/09 at 3:30 PM, the Director of Nursing (DON) was shown Resident #3 and 16's plan of care. The DON nodded her head to verify that the care plan did not address what to do for emergency bleeding. The DON stated, &quot;They are to call the doctor if they can't stop the bleeding.&quot;</td>
<td>F 280</td>
<td>3. Measures to prevent recurrence: Nursing staff will receive in-service education provided by the Staff Development Coordinator or designee by 4/23/09 regarding revised care plan interventions for dialysis residents for the potential for bleeding, and to ensure that interventions are added to the immediate care plan to address the potential for bleeding for newly admitted residents requiring dialysis. The MDS Coordinator will review the care plans of residents requiring dialysis to ensure that care plan interventions are in place regarding the current status for bleeding.</td>
<td>3/24/2009</td>
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<tr>
<td>F 332</td>
<td>483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater.</td>
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<td>3/24/2009</td>
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This REQUIREMENT is not met as evidenced by:

- Medical record review for Resident #3 documented an admission date of 1/19/07 with diagnoses of Chest Pain, Diabetes, Weakness, Dyspnea and General Anxiety. Review of the plan of care updated 2/10/09 documented Resident #3 received dialysis and "Observe for excessive bleeding and notify MD [medical doctor] if unable to stop bleeding." The care plan did not address measures to be put in place to stop emergency bleeding.
- Medical record review for Resident #16 documented an admission date of 12/1/05 with diagnoses of Renal Failure, Malaise, Muscle weakness, Diabetes, Hypertension, Cataracts and Heart Disease. Review of the plan of care updated 1/29/09 documented Resident #16 received dialysis and "Monitor for excessive bleeding and notify MD if unable to stop bleeding." The care plan did not address measures to be put in place to stop emergency bleeding.
- During an interview in the conference room on 3/24/09 at 3:30 PM, the Director of Nursing (DON) was shown Resident #3 and 16's plan of care. The DON nodded her head to verify that the care plan did not address what to do for emergency bleeding. The DON stated, "They are to call the doctor if they can't stop the bleeding."
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 445448

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ____________________________
B. WING ________________________________

(X3) DATE SURVEY COMPLETED 03/24/2009

NAME OF PROVIDER OR SUPPLIER
MONTGOMERY CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
198 OLD FARMER ROAD
CLARKSVILLE, TN 37043

(X4) ID PREFIX TAG
SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
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(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5) COMPLETION DATE __________

F 332 Continued From page 5

Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure 4 of 7 (Nurses #1, 3, 6 and 7) nurses observed during the medication administration pass administered medications with an error rate of less than five percent (%). There were 8 medication errors out of 40 opportunities for errors, which resulted in a medication error rate of 20%.

The findings included:

1. Review of the facility's "Medication Administration - Administering Medications (Licensed Staff)" documented, "...4. Review the five (5) right of medication administration during preparation and administration process. "Right medication *Right dosage *Right resident *Right time *Right route..."

2. Medical record review for Random Resident (RR) #1 documented an admission date of 10/16/07 with diagnoses of Cerebral Palsy, Urinary Tract Infection, Pneumonia and Failure To Thrive. Review of a physician's order dated 1/27/09 documented, "...Change all meds [medications] to per tube." Review of a physician's recertification order dated 2/20/09 documented, "...COLACE 100MG [milligram] CAPSULE 1 CAPSULE BY MOUTH TWICE DAILY, 10AM and 9PM, POTASSIUM CL [CHLORIDE] 20 MEQ [MILLIEQUIVALENT] TAB ER 1 TABLET BY MOUTH TWICE DAILY, PRIMIDONE 250 MG 1 TABLET THREE TIMES DAILY, 10:00 AM, 1:00 PM and 9:00 PM..."

Observations in RR #1's room on 3/22/09 at 4:37 PM, revealed Nurse #1 administered KCL 10 meq and Primidone 250 mg. The administration of

F 332:

1. Immediate Intervention:
The Physician was notified regarding the medication error(s) for random resident # 1 and 2 on 3/25/09.

2. Identification of the residents with potential to be affected:
An audit will be completed by the Nursing Administrative Team by 4/23/09 to ensure medications were being administered as ordered.

3. Measures to prevent reoccurrence:
The Nurses involved in medication errors will receive one on one education regarding medication administration to include the 5 rights of medication administration by 4/23/09 provided by the Staff Development Coordinator or designee. Education will be provided for licensed nurses regarding appropriate medication administration to include the 5 rights of medication administration provided by the Staff Development Coordinator or designee by 4/23/09. The Staff Development Coordinator, Assistant Director of Nursing, or the Pharmacy Consultant will complete medication pass audits with the nurses involved in medication errors and with three licensed nurses monthly for three months to ensure that medications are administered as ordered.

4. Monitoring:
Findings of the medication administration audits will be presented to the Quality Assurance Committee monthly for 3 months for recommendations and follow-up.
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<td>F 332</td>
<td>Continued from page 6</td>
<td>KCL 10 meq instead of 20 meq resulted in medication error #1 and the administration of the Primidone 4 and 1/2 hour before the scheduled time resulted in medication error #2. Observations in RR #1's room on 3/23/09 at 8:02 AM, revealed Nurse #3 administered Colace 50 mg and Primidone 250 mg. The administration of Colace 50 mg instead of 100 mg resulted in medication error #3. The administration of the Primidone 250 mg 1 hour before the scheduled time resulted in medication error #4. Observations in RR #1's room on 3/23/09 at 4:03 PM, revealed Nurse #7 administered Primidone 250 mg and Colace 10 cubic centimeters. The administration of the Primidone 5 hours before the scheduled time resulted in medication error #5. The administration of the Colace liquid without a physician's order resulted in medication error #6. During an interview in the conference room on 3/23/09 at 11:55 AM, the Director of Nursing (DON) stated, &quot;Yes, it's confusing [referring to the resident's orders and Medication Administration Record] I'll call the doctor and get it straightened out. The order was changed from capsule to tablets because we were short of capsules at one time. I can't find an order for the liquid potassium or the Colace. We missed that, should have caught it.&quot; During an interview in the conference room on 3/24/09 at 1:10 PM, the DON stated, &quot;That's my fault when the order was written to give all meds per peg [percutaneous endoscopic gastrostomy] tube the pharmacy just changed it [colace] to liquid.&quot;</td>
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<td>F 332</td>
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<td>3. Medical record review for RR #2 documented an admission date of 2/8/06 with diagnoses of Diabetes Mellitus, Senile Dementia, Bipolar Affective Disorder, Neurotic Depression, Hypertension and Osteoarthritis. Review of a physician's order 1/30/09 documented, &quot;...FIBER-LAX 1 CAPSULE BY MOUTH TWICE DAILY BEFORE BREAKFAST AND BEFORE DINNER &quot;GIVE WITH 8 OZ [ounce] OF H2O [water], KLOPIN 1 MG TABLET BY MOUTH THREE TIMES DAILY, 8:00 AM, 2:00 PM and 8:00 PM...&quot;</td>
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<td>Observations in RR #2's room on 3/23/08 at 3:50 PM, revealed Nurse #6 administered Fiber-Lax and Klonopin 1 mg. The failure to administer the Fiber-Lax with 8 oz of H2O resulted in medication error #7 and the administration of the Klonopin 4 hours and ten minutes before the scheduled time resulted in medication error #8.</td>
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<tr>
<td>F 502</td>
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<td>493.7501(1) LABORATORY SERVICES</td>
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<td>SS=D</td>
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<td>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, it was determined the facility failed to provide laboratory services in a timely manner for 1 of 23 (Resident 17) sampled resident.</td>
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<td>The findings included: Review of the facility's &quot;Lab [laboratory]&quot;</td>
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<td>2. Identification of the residents with potential to be affected: A laboratory audit was completed by 2/27/09 by the Nursing Administration Team to identify other lab studies not completed as ordered.</td>
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| F 502 | Continued From page 8 | Protocol/Diagnostic Testing" policy documented, "Policy: It is the primary purpose of diagnostic services to provide uniform procedures for obtaining necessary diagnostic services when ordered by the attending physician... Procedure... Assure that the residents receive laboratory...services as ordered by the attending physician."


During an interview in the conference room on 3/24/09 at 1:20 PM, the Director of Nursing verified that the October 2008 HGB AIC, CMP and CBC levels were not done as ordered.

3. Measures to prevent reoccurrence:
A system was initiated by the Quality Assurance Committee upon identification of the missing laboratory study to ensure that laboratory studies are completed as ordered. The Assistant Director of Nursing receives a copy of physician orders. She reviews the laboratory calendar to ensure studies are scheduled or have been drawn as ordered. She continues to follow up until the results have been received and the physician has been notified of findings. Nursing staff will receive in-service education by 4/23/09 regarding the system to ensure labs are completed as ordered as presented by the Staff Development Coordinator of designee. A lab audit will be completed monthly by the Assistant Director of Nursing or designee to ensure lab studies have been completed as ordered.

4. Monitoring:
Findings of the above stated audit will be presented to the Quality Assurance Committee monthly for 3 months for recommendations and follow-up.