<table>
<thead>
<tr>
<th>(X4) 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-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 164</td>
<td>483.10(e), 483.75((j)(4)) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</td>
<td>F 164</td>
<td>483.10(e), 483.75((j)(4)) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</td>
<td></td>
</tr>
<tr>
<td>SS=D</td>
<td>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</td>
<td></td>
<td>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</td>
<td></td>
<td>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
<td>The facility will 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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain full visual privacy for residents in 7 of 35 (4, 5, 6, 11, 28B, 31 and 35) resident rooms.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
F 164
Continued From page 1
The findings included:

1. Observations on the Women's hall on 6/19/13
beginning at 4:26 PM revealed the following:
a. Room 4 - there was no privacy curtain.
b. Room 5 - there was no privacy curtain.
c. Room 6 - there was no privacy curtain.
d. Room 11 - there was no privacy curtain.

2. Observations on the Men's hall on 6/18/13
beginning at 3:39 PM revealed the following:
a. Room 28B - there was no privacy curtain to
provide full visual privacy.
b. Room 31 - there was no privacy curtain.
c. Room 35 - there was no privacy curtain.

During an interview on the men's hall on 6/20/13
at 10:00 AM, Nurse #2 verified there were no
privacy curtains in the above listed rooms.

3. During an interview in the office area on
6/20/13 at 10:25 AM, the administrator was given
a list with rooms numbers of the rooms without
privacy curtain. In a subsequent interview in
the office area on 6/20/13 at 10:32 AM, the
administrator verified there were no privacy
curtains in the above listed rooms.

F 272
483.20(b)(1) COMPREHENSIVE
SS=D
ASSESSMENTS

The facility must conduct initially and periodically
a comprehensive, accurate, standardized
reproducible assessment of each resident's
functional capacity.

A facility must make a comprehensive
assessment of a resident's needs, using the
resident assessment instrument (RAI) specified

F 164
Continued From Page 1

CORRECTIVE ACTION:

1. On 6/28/13, new privacy curtains
were ordered for rooms 4, 5, 6, 11,
28B, 31, and 35. Privacy curtains will
be installed in these rooms to
provide full visual privacy.

An in-service was done on 7/10/13 to
assure that staff will provide as
much privacy with care as possible
until the privacy curtains are installed.

2. On 6/28/13, the Maintenance
Supervisor and Housekeeping
Supervisor inspected the facility to
ensure that privacy curtains will be
installed in all rooms to provide full
visual privacy to all residents.

3. On 7/01/13, the Maintenance
Supervisor and Housekeeping
Supervisor were in-service by the
Administrator on the requirements for
privacy curtains in all rooms.

4. The Housekeeping Supervisor,
Maintenance Supervisor, and
Administrator will monitor for
compliance through facility rounds
weekly and report the findings to the
Quality Assurance Committee.

DATE OF COMPLETION:
7/16/2013
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 272</td>
<td>Continued From page 2 by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This <strong>REQUIREMENT</strong> is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to completely assess for physical therapy (PT) for 1 of 3 (Resident #21) sampled residents reviewed of the 29 residents included in the stage 2 review.</td>
</tr>
</tbody>
</table>
**F 272** Continued From page 3

The findings included:

Medical record review for Resident #21 documented an admission date of 2/22/13 with diagnoses of Polyneuropathy, Atony of bladder and Hypothyroidism. Review of a physician’s order dated 2/25/13 documented, "...PT [physical therapy] to eval [evaluate] and treat as indicated. PT clarification order: PT to treat 3x [times] wk [week] x 8 wks..." Review of the Minimum Data Set (MDS) with an assessment reference date (ARD) of 2/28/13 revealed section P - Special Treatments and Procedures was marked for Range of Motion but was not marked for PT.

During an interview in the office area on 6/19/13 at 1:45 PM, the Minimum Data Set (MDS) Nurse was asked if PT should be coded on the MDS with an ARD of 2/28/13. The MDS Nurse stated, "Yes, it should. They [PT] had just picked her up so I might have missed it..."

**F 280**

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.
F 280 Continued From page 4
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 a pressure ulcer or fall for 2 of 17 (Residents #9 and 23) sampled residents of the 29 residents included in the stage 2 review.

The findings included:

1. Review of the facility's care plan policy documented, "As physicians orders are reviewed and updated monthly, the nursing care plan will also be reviewed and updated monthly, the nursing care plan will also be reviewed with the resident or specified designee..."

2. Medical record review for Resident #9 documented an admission date of 6/16/09 with diagnoses of Alzheimer's with Delusions, Chronic Renal Failure, Dementia with Behavior Disturbances, Peripheral Neuropathy, Constipation, Congestive Heart Failure, Hypertension, Diabetes Mellitus and Fluid Retention. Review of the wound report dated 4/2/13 documented "...SITE: AL [left] heel... DATE FIRST OBSERVED 04-02-13... deep tissue injury... calloused area..." The wound...
F280 Continued From page 5

Report documented dates, location and progress of the pressure ulcer from 4/2/13 through 6/18/13. Review of the care plan dated 5/3/13 revealed there was no documentation of the pressure ulcer describing what, where, when it occurred or treatment.

Review of the physician's telephone order dated 6/11/13 documented, "...treatment to left heel. Clean with SWC [skin integrity wound cleanser]; apply granulox on foam pad to area on heel & [and] wrap with gauze daily and pm [as needed] until clear..."

Observations in Resident #9's room on 6/19/13 at 10:40 AM, revealed Nurse #4 performing wound care on Resident #9's left heel.

During an interview in the front office on 6/19/13 at 1:55 PM, the Minimum Data Set Nurse stated, "I'm going to update it [care plan]."

3. Medical record for Resident #23 documented an admission date of 9/8/11 with diagnoses of Atrial Fibrillation, Alzheimer's Disease, Anxiety, Congestive Heart Failure, Hypertension, Dementia, Chronic Obstructive Cardiopulmonary Disease, Osteoarthritis, Constipation and Diarrhea. Review of the fall risk assessment dated 4/19/13 documented a score 12. Total score of 10 or above represents a high risk for falls.

Review of nurse's notes dated 6/17/13 documented "...bed alarm was sounding... she was lying on the floor... no apparent injury... instructed to position with pillows to prevent resident from rolling out of bed..." Review of an incident report dated 6/17/13 documented, CORRECTIVE ACTION:

1. On 6/19/13, the care plan for Resident #9 was revised and updated by the MDS Coordinator to reflect the pressure ulcer and treatment being performed. The care plan for Resident #23 was updated to include interventions for the fall sustained on 6/17/13.

2. On 7/5/13, the MDS Coordinator conducted chart audits to ensure the care plans were updated to reflect the current status of the residents.

3. On 7/4/13, an inservice was conducted by the DON with the MDS Coordinator to ensure care plans reflect all wounds, current treatments, and fall interventions.

4. The DON and MDS Coordinator will monitor for compliance through monthly chart audits and report findings to the QA Committee quarterly.

COMPLETION DATE:

7/5/2013
F 280 Continued From page 6
"resident rolled over and rolled out of bed onto floor mat.
Review of the care plan dated 4/9/13 was not updated to include interventions for the fall sustained on 6/17/13.

F 282
483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation and interview, it was determined the facility failed to ensure the care plan interventions for a fall were implemented for 1 of 5 (Resident #21) sampled residents with falls of the 29 residents included in the stage 2 review.

The findings included:
Medical record review for Resident #21 documented an admission date of 2/22/13 with diagnoses of Polymyalgia Rheumatica, Atony of bladder and Hypothyroidism. Review of the fall risk assessment dated 2/22/13 was coded with a score of 20 and the fall risk assessment dated 3/24/13 was coded with a score of 18. A score of 10 or above indicated the resident was assessed as a high risk for falls. Review of the care plan dated 5/24/13 documented, "...Problem / Needs... Resident is at risk for injuries r/t [related to] Hx [history] of falls... Approaches... Hipster while OOB [out of bed]... Low bed..."
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA ID</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification Number: 445508</td>
<td>A. BUILDING</td>
<td>06/20/2013</td>
</tr>
<tr>
<td>B. WING</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

**OBION COUNTY NURSING HOME**

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

**1084 EAST COUNTY HOME ROAD**  
**UNION CITY, TN 38281**

**F 282**  
Continued From page 7

Observations in Resident #21’s room on 6/19/13 at 10:45 AM, revealed Resident #21 seated in a wheelchair (w/c) at bedside with a chair alarm in place. Resident #21 was asked if she had her hipsters on, Resident #21 stated, “No, I’m not wearing them today.”

Observations in Resident #21’s room on 6/19/13 at 1:25 PM, revealed Resident #21 seated on her bed with the bed positioned in a high position.

During an interview on the Men's hall on 6/19/13 at 1:30 PM, while walking down the hall Nurse #1 stated, “Oh, her [Resident #21] bed is up to high...” Nurse #1 was asked to check and see if the resident had her hipsters on. Nurse #1 asked Resident #21 if she had her hipsters on. Resident #21 stated, “No I don’t have them on. They quit putting them on me a long time ago when I got better.” Nurse #1 stated, “Well, they weren’t suppose to...”

The facility staff failed to follow the care plan interventions for Resident #21 to wear hipsters and place the bed in the low position.

**F 323**  
**483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES**

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

<table>
<thead>
<tr>
<th>ID</th>
<th>PRECISION TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 282</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 323</td>
<td></td>
<td>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES REQUIREMENT:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The facility will ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</td>
</tr>
</tbody>
</table>

**FORM CMS-2567(02-99) Previous Versions Obsolete**  
Event ID: K1MB11  
Facility ID: TN3602  
If continuation sheet Page 8 of 18
**Corrective Action: 1.**
On 6/20/13, MD and family were notified of the resident’s refusal to wear hipsters. On 7/10/13, the staff members were instructed to monitor and ensure the bed is in the lowest position. The resident was instructed on the use of bed controls and the need to keep the bed in the lowest position. The care plan for Resident #21 was revised and updated by the MDS Coordinator to reflect the current safety interventions.

**Corrective Action: 2.**
On 7/8/13, the MDS Coordinator conducted a fall audit on all care plans to ensure fall interventions were being followed.

**Corrective Action: 3.**
On 7/10/13, an in-service was conducted by the DON with all staff to ensure that care plan interventions for falls were followed for the resident’s safety.

**Corrective Action: 4.**
The DON and MDS Coordinator will monitor for compliance through monthly care plan audits and all findings will be reported to the QA Committee quarterly.

**Completion Date:** 7/10/2013
Continued From page 9 stated, "Oh, her [Resident #21] bed is up to high..." Nurse #1 was asked to check and see if the resident had her hipsters on. Nurse #1 asked Resident #21 if she had her hipsters on. Resident #21 stated, "No I don't have them on. They quit putting them on me a long time ago when I got better." Nurse #1 stated, "Well, they weren't suppose to..."

The facility staff failed to follow the fall interventions of hipsters and placing the bed in a low position for Resident #21.

F 329 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.
This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation and interview, it was determined the facility failed to consistently monitor signs and symptoms for hypertensive medications for 1 of 10 (Resident #5) sampled residents reviewed for unnecessary medication usage included in the stage 2 review.

The findings included:

Medical record review for Resident #5 documented an admission date of 4/9/13 and diagnoses of Osteoarthritis, Hyperlipidemia, Diabetes Mellitus, Depression, Dementia, Blindness, Macular Degeneration, Rotator Cuff Disease, Joint Pain, Constipation, Allergies, Neuropathy, Hypertension, Skin Disorder, Vitamin D Deficiency, Anemia, and Stomach Function Disorder. Review of the care plan dated 4/12/13 documented " Resident is at risk for alteration in tissue perfusion due to Dx [diagnosis] Hypertension ...listed Imdur 50 mg [milligrams] po [by mouth] daily. Cozaar 100mg po daily. Norvasc 2.5mg po daily." There was no documentation about risk of hypotension or signs to monitor for.


483.25(1) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

REQUIRED:
Each resident's drug regimen will be free from unnecessary drugs.

CORRECTIVE ACTION:
1. On 6/19/13, the MD was notified of blood pressure readings on Resident #5. The blood pressure medications were held with blood pressure recorded every shift until medications were discontinued on 6/24/13.

2. On 7/19/13, the DON resubmitted the charge nurses to get orders to discontinue unnecessary drugs.

3. On 7/11/13, the DON and MDS Coordinator audited charts and received orders to discontinue unnecessary drugs. The DON and MDS Coordinator will conduct random and monthly chart audits for compliance.

4. The DON and MDS Coordinator will monitor for compliance through monthly chart audits. The findings will be reported to the QA Committee quarterly.

COMPLETION DATE:
7/12/2013
Continued From page 11

5/28/13 revealed the following: "To: [Named physician] From: the Director of Nursing (DON) "Resident is complaining about the amount of medication she is taking. Please review per family request for possible decrease in unnecessary medications. Resident also requesting not to take any meds before breakfast. Can these be changed? Pepcid and Metformin."
"Reply was change Docosate to PRN [as needed], Mucinex DM to PRN, Flonase to PRN pepcid and Metformin can be with lunch and supper."

Review of a psychotropic note dated 5/30/13 documented," D/C [discontinue] Risperdal po [by mouth] Q [every] HS [hour of sleep]...Risperdal every other HS x [times] 14 days; D/C Hand written note on this documented, "NAV [nausea and vomiting] with med taking. Staff feel she will do better if she had less meds PCP [Primary Care Physician] to eval [evaluate] other meds."

Review of a "Significant Change in Status" dated 5/30/13 documented, "Please review and D/C [discontinue] any unnecessary meds Especially OTC [over the counter] meds - Resident does not want to take very many meds @ [at] all."

Review of the "Vital Signs and Weight log" documented a BP on 6/6/13 as 91/55. Additional B/Ps provided by staff were as followed 6/9/13 - 106/61; 6/17/13 - 132/68 and 6/19/13 - 12:10 PM 109/44 and 2:40 PM - 86/36.

Review of the Medication Administration Record for June 2013 documented, "...residents has "refused" morning meds for the last 3 days due to not feeling well." This included hypertensive medications.
### Continued From page 12

Observations on 6/19/13 at 2:46 PM, Nurse #1 took a manual blood pressure per doctor orders with a reading of 102/56. The doctor was notified of the B/P and a new order was given to hold blood pressure medications for now and orthostatic blood pressures each shift.

During an interview at the nurses' desk on 6/18/13 at 10:30 AM, the Medical Director was asked about cardiac medications for Resident #5. The Medical Director stated, "...she is on a lot of medications. She had a couple low [blood] pressures. I would like to see blood pressures taken at random times and not all at the same time of day. They should take blood pressures in both arms for verifications. I would want verifications of what her actual pressures are..."

During an interview at the nurse's desk on 6/19/13 at 11:40 AM, the Pharmacy Consultant stated, "We can certainly call the doctor and ask about them [meds]... definitely could decrease one of the meds."

During an interview in the Minimum Data Set Nurse's office on 6/20/13 the MDS Nurse stated, "We just follow the nursing standard of care for blood pressures. We don't have a policy for blood pressures. We just note the signs and symptoms and if present we call the doctor."

F 332 - 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.
Continued From page 13

This REQUIREMENT is not met as evidenced by:

Based on policy review, review of Lexi-Comp's Geriatric Dosage Handbook, observation and interview, it was determined the facility failed to ensure 2 of 4 (Nurses #2 and 3) nurses administered medications with a medication error rate of less than 8 percent (%) for Residents #2 and 56. There were 2 medication errors out of 26 opportunities for error, which resulted in a medication error rate of 7.6%.

The findings included:

1. Review of Lexi-Comp's Geriatric Dosage Handbook 12th edition documented, "...Insulin glulisine (Apidra...) should be administered within 15 minutes before or within 20 minutes after start of meal..." on page 799.

Medical record review for Resident #2 documented an admission date of 7/24/12 with diagnoses of Constipation, Status Post Cerebrovascular Accident, Anemia, Diabetes, Hypertension, Alzheimer's Disease, Anxiety and Depression. Review of the physician's orders for Resident #2 dated 6/19/13 documented, "...APIDRA SS [sliding scale]... 301 - [to] 350 5 UNITS..."

Observations of medication administration in Resident #2's room on 6/18/13 at 11:48 AM, Nurse #2 administered 5 units of Apidra insulin for a blood glucose result of 329. Resident #2 did not receive or begin eating a meal until 12:21 PM, 33 minutes after administration of the Apidra insulin. The failure to administer the Apidra insulin

<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F332</td>
<td><strong>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% MORE</strong>&lt;br&gt;REQUIREMENT:&lt;br&gt;The facility will ensure that it is free of medication rates of five percent or greater.&lt;br&gt;CORRECTIVE ACTION:&lt;br&gt;1. On 7/05/13, Nurse #2 and #3 were inservices on the correct procedure for administration of insulin in relation to meals.&lt;br&gt;2. On 7/10/13, the nursing staff was inservices on the correct procedures for administration of insulin in relation to meals.&lt;br&gt;3. The DON will conduct random med pass audits with all licensed nurses between 7/10 and 7/13/13, to ensure the licensed staff is in compliance with the proper administration of insulin in relation to meals.&lt;br&gt;4. The DON, MDS Coordinator, or Pharmacy Consultant will monitor for compliance through monthly med pass audits. The findings will be reported to the QA Committee quarterly.</td>
<td>F332</td>
<td><strong>COMPLETION DATE:</strong> 7/13/2013</td>
</tr>
<tr>
<td>ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID PREFIX TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)</td>
</tr>
<tr>
<td>---------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>---------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| F 332         | Continued From page 14 within 15 minutes of Resident #2's meal resulted in medication error #1.  
During an interview on the Women's hall in front of the dining room on 6/20/13 at 12:04 PM, Nurse #2 stated, "...they [residents] should eat within 30 minutes of getting regular insulin..."  
2. Review of Lexi-Comp's Geriatric Dosage Handbook 12th edition documented, "...With insulin aspart (NovoLog...) you must start eating within 5-10 minutes after injection..." on page 799.  
Review of the facility's meals and insulin administration policy documented, "...Novolog... should be given 5-10 min [minutes] before the resident eats..."  
Medical record review for Resident #56 documented an admission date of 6/11/13 with diagnoses of Hypertension, Neurogenic Bladder, Multiple Decubitus Ulcers, Urinary Tract Infection, Functional Quadriplegic, Dementia, Metabolic Encephalopathy, Dehydration, Failure to Thrive, Diabetes, Coronary Artery Disease, History of Cerebrovascular Accident and Myocardial Infarction, Congestive Heart Failure and Hyperlipidemia. Review of the physician's orders dated 6/11/13 documented, "...NOVOLOG 100 UNIT/ [per] ML [milliliter] VIAL GIVE ACCORDING TO SLIDING SCALE... 201-250= [amount of insulin to be administered] 5 [units]..."  
Observations of medication administration in Resident #56's room on 6/18/13 at 11:58 AM, Nurse #3 administered 5 units of Novolog Insulin for a blood glucose result of 215. Resident #56 | F 332 | | | |
**F 332**: Continued From page 15

did not receive or begin eating a meal until 12:17 PM, 19 minutes after administration of Novolog insulin. The failure to administer the Novolog insulin within 10 minutes of Resident #56's meal resulted in medication error #2.

3. During an interview in the Director of Nursing’s (DON) office on 6/20/13 at 10:27 AM, the Minimum Data Set (MDS) Nurse was asked about insulin administration. The MDS Nurse stated, "I will have to check the policy..."

During an interview in the employee lounge on 6/20/13 at 11:42 AM, the MDS nurse stated, "...the policy says they [residents] should be given something to eat within 30 minutes... Novolog should be 5 to 10 minutes..."

**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 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
Continued From page 16

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, observation and interview, it was determined the facility failed to ensure practices to prevent the potential spread of infection were maintained during disposal of sharps by 1 of 2 (Nurse #2) nurses observed performing a finger stick for a blood glucose level.

The findings included:

Review of the facility's handling of contaminated sharps policy documented, "...All contaminated sharps are to be placed in a safety sharp container immediately..."

Observations in Resident #2's room on 6/18/13 at 11:38 AM, Nurse #2 performed an accucheck on Resident #2. After completing the accucheck,
F 441 Continued From page 17

Nurse #2 placed the used lancet, strip, and alcohol pads in her gloved left hand. Nurse #2 removed the glove from her left hand wrapping the glove around the used lancet, strip, and alcohol pad and discarded them in the trash receptacle on the Men's hall medication cart.

During an interview on the Men's hall on 6/20/13 at 9:34 AM, Nurse #2, stated, "...I wrapped it [lancet] in my glove and put it in the trash... I should have put it in the sharps box..."

During an interview in the Director of Nursing's office on 6/20/13 at 10:25 AM, the Minimum Data Set (MDS) Nurse, was asked how items used for accuchecks should be disposed of. The MDS nurse stated, "...I expect the nurses to throw the sharps in the sharps container using gloved hands..."