## Initial Comments

An onsite visit was conducted during the annual recertification survey on August 9, 2010, thru August 11, 2010, at NHC Murfreesboro to investigate 463.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE.

The facility failed to assess resident #8 for self-administration of medication.

### F 176

#### Resident #8 was assessed for self administration on the nebulizer medication on 8/18/10. All patients receiving nebulizer medications will be assessed for self administration by 8/27/10. In-services were conducted by the DON for the Licensed Nurses on 8/16/10, 8/17/10, 8/23/10, and 8/31/10 regarding self administration of nebulizers and observation of patients receiving nebulizers. The DON or her designee will conduct a quality assurance study regarding nebulizer medication administration monthly for 3 months and then continue at the discretion of the Quality Assurance Committee.
F 176: Continued From page 1

and Xopenex (bronchodilator) 0.63 mg by a nebulizer treatment.

Medical record review revealed no documentation the resident had been assessed for self-administration of medications.

Observation on August 9, 2010, at 3:06 p.m., revealed the resident sitting in an electric wheelchair, unattended, receiving a nebulizer treatment. Continued observation revealed the bottom of the nebulizer mask was located in the resident's mouth.

Observation and interview on August 9, 2010, at 3:10 p.m., with Licensed Practical Nurse (LPN) #2, revealed the resident sitting in the electric wheelchair, with the bottom of the nebulizer mask located in the resident's mouth. Interview with LPN #2, at the time of the observation, revealed the nebulizer mask had been placed on the resident approximately 30 minutes prior to the observation. Continued interview with LPN #2 confirmed the resident had not been assessed for self-administration of medications.

F 246: 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES

A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

This REQUIREMENT is not met as evidenced by:
**F 246**

Based on observation, and interview, the facility failed to provide a call light within reach for one (#31) of thirty-three residents reviewed.

The findings included:

- Resident #31 was admitted to the facility on August 2, 2008, with diagnoses including Dementia, History of Deep Vein Thrombosis, Contractures, Hypertension, and Chronic Pain.
- Review of the Minimum Data Set (MDS) dated July 1, 2010, revealed the resident had difficulty with long and short term memory, moderate difficulty with decision making skills, and required assistance with all activities of daily living.
- Observation on August 11, 2010, at 9:10 a.m., revealed the resident lying in the bed, and requesting a bed pan. Continued observation at the same time, revealed the call light had been placed on the bed side table out of the resident's reach.
- Interview with Certified Nursing Assistant (CNA #5) on August 11, 2010, at 9:10 a.m., in the resident's room, confirmed the resident needed to use the bed pan and the call light was not in the resident's reach.

**F 281**

- **SS-D**
- 483.20(k)(3)(I) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced.

---

**F 246**

The call light for resident #31 was put into the patient's reach upon notification to the staff that it was not accessible to the patient. All patients at that time were checked for accessible call lights. In-services were conducted for nursing partners on 8/15/10, 8/17/10, 8/23/10 and 8/31/10. A quality assurance study will be conducted by the DON or her designee monthly until 100% compliance is met and then as directed by the Quality Assurance Committee.

**8/31/10**
F281

Continued From page 3

by:

Based on medical record review, observation, and interview, the facility failed to follow the physician's orders for one (#12) of thirty-three residents reviewed.

The findings included:

Resident #12 was admitted to the facility on August 11, 2009, with diagnoses including Iron Deficiency Anemia, Congestive Heart Failure, Atrial Fibrillation, Chronic Kidney Disease, Diabetes with Neurological Manifestations, Peripheral Neuropathy, Anxiety, Depression, and Insomnia.

Medical record review of a physician's order dated July 7, 2010, revealed the resident was to receive Procrit (medication to treat anemia) 40,000 units subcutaneously every three weeks, and to hold or not administer the medication if the hemoglobin was greater than 12 or the hematocrit was greater than 32. Medical record review of a physician's order dated July 19, 2010, revealed the hemoglobin and hematocrit were to be checked every month.

Medical record review of a laboratory report dated July 6, 2010, revealed the hemoglobin was 9.3 (reference range 11.5-15.5) and the hematocrit was 27.9 (reference range 38.0-45.0).

Medical record review of the July 2010 Medication Record revealed the Procrit was administered on July 8, 2010, and a box on the Medication Record indicated the Procrit was also to be administered on July 29, 2010. Continued review of the July 2010 Medication Record revealed the Procrit was not initialed as

F281

The MD was notified of the missed Procrit on resident #12 on 8/9/10 and the medication was discontinued per the physicians order. An review of all July MAR's was conducted by the unit managers on 8/10/10 to check for omitted medications. In-services regarding missed medications were conducted for Licensed Nurses by the DON on 8/10/10, 8/16/10, 8/17/10, 8/23/10, and 8/31/10. A quality assurance study regarding missed medications will be conducted monthly for 3 months and then as directed by the Quality Assurance Committee.

8/31/10
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR IGC IDENTIFYING INFORMATION)</th>
<th>PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 281</td>
<td>Continued From page 4</td>
<td>administered on July 29, 2010. Observation on August 9, 2010, at 1:30 p.m., revealed the resident lying on a low bed, with bilateral floor mats in place. Interview on August 9, 2010, at 2:35 p.m., with Licensed Practical Nurse (LPN) #1, nurse responsible for the administration of the Proctor on July 29, 2010, in the nursing station, confirmed the Proctor was not administered as ordered on July 29, 2010.</td>
<td>F 281</td>
</tr>
<tr>
<td>F 371</td>
<td>483.35(i) FOOD PROCURE, STORE/prepare/SERVE - SANITARY</td>
<td>The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions.</td>
<td>F 371</td>
</tr>
</tbody>
</table>

NHC Murfreesboro does maintain the dietary department in a clean and sanitary manner. The dish machine was inspected by Ecolab on 8/26/10. A new machine wash temperature thermostat and a heating element were installed. Thermosets and gauges were calibrated. Machine tested at a minimum of 160 degrees during wash cycle. Machine is working properly above minimum 160 degree wash temperature. Continuous monitoring will be maintained to ensure proper wash temperatures. All pans of various sizes were checked for wet nesting and pulled from shelves and re-washed immediately. Another drying shelf was purchased and delivered on 8/20/10. The two compartment sink table was cleaned and all debris removed around the table legs, and along the floor of the lower shelf. The rest of the kitchen was inspected for cleanliness on 8/9/10. Staff was in-service on proper cleaning of shelf and cleaning off on cleaning list. The steam table in the front tray line was checked for proper temperature range. The pork chops and hamburger patties were reheated and then served to the patients. Inservices were conducted on 8/10/10 to dietary.
F 371: Continued From page 5
recommended by the manufacturer, of 160 degrees F. during the wash cycle. Continued observation revealed the wash temperature reached 155 degrees F. Continued observation on August 9, 2010, at 10:35 a.m., revealed the dishwasher temperature reached 160 degrees F. Observation of the metal plate on the side of the dishwasher indicated the wash temperature should reach 160 degrees F.

Continued observation on August 9, 2010, at 9:45 a.m., with the Dietary Manager and the R.D., revealed twenty-seven pans, of various sizes, were stacked and stored wet.

Continued observation on August 9, 2010, at 9:50 a.m., revealed an eight foot, two compartment sink table had food, moisture, and debris built up around the table legs, and along the front edge of the lower shelf.

Interview with the Registered Dietitian and Dietary Manager on August 9, 2010, at 10:40 a.m., in the kitchen, confirmed the dishwasher, hot temps, did not reach the manufacturer's recommendations; twenty-seven pans were stacked and stored wet, and the table had food, moisture, and debris built up on the second (lower) shelf.

Observation of the hot food temperatures on August 10, 2010, at 11:50 a.m., with the Dietary Manager and the Registered Dietitian, of the front tray line, revealed the temperatures of the Pork Chops and Hamburger Patties were below the recommended hot food temperatures of 140 degrees F. or above. Continued observation of the Front Tray Line, revealed the Pork Chops were 130 degrees F. and the Hamburger Patties were 120 degrees F. Both the Pork Chops and
**F 371**
Continued from page 6

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This **REQUIREMENT** is not met as evidenced by:

Based on medical record review and observation, the facility failed to ensure a medication was

**F 425**

<table>
<thead>
<tr>
<th>ID</th>
<th>PROVIDER PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLIANCE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 425</td>
<td><strong>F 425</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Resident #12</strong> received her eye drops starting on 7/13/10 to current. A review of all MAR's was conducted to check for missed medications secondary to not being available from the pharmacy. A meeting with the pharmacy was conducted on 8/19/10 on procedures for medications not available. In-services for licensed nurses were conducted by the DON regarding medications not available on 8/16/10, 8/17/10, 8/23/10 and 8/31/10. A quality assurance study will be conducted to check for medication availability monthly for 3 months and then as directed by the Quality Assurance Committee.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>8/31/10</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**F 371** cont.

Staff on the cleaning schedule, proper procedures for storage of drying pans and monitoring of food items found below standard. The Dietitian will conduct a QA study on wet heating, sanitation and food temperatures 3 x week for 1 month, monthly x 2 months, then as directed by the Quality Assurance Committee.

**8/26/10**
F 425: Continued From page 7
available for one (#12) of thirty-three residents reviewed.

The findings included:

Resident #12 was admitted to the facility on August 11, 2009, with diagnoses including Iron Deficiency Anemia, Congestive Heart Failure, Atrial Fibrillation, Chronic Kidney Disease, Diabetes with Neurological Manifestations, Peripheral Neuropathy, Anxiety, Depression, and insomnia.

Medical record review of the July 2010, physician's recapsitulation orders revealed the resident was to receive Patanol (medication to treat allergic conjunctivitis) 0.1% ophthalmic solution one drop to each eye twice a day.

Medical record review of the July 2010, Medication Record revealed the Patanol was circled as not administered on July 12, 13, and 14, 2010. Medical record review of the reverse side of the July 2010, Medication Record revealed on July 13, 2010, "Patanol gits (drops) not available-ordered from pharmacy."

Interview on August 10, 2010, at 7:10 a.m., with Licensed Practical Nurse (LPN) #3 (nurse responsible for the administration of the Patanol on July 12, 13, and 14, 2010), at the nursing station, confirmed the Patanol was not available on July 12, 13, and 14, 2010.

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
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

NHC HEALTHCARE, MURFREESBORO

STREET ADDRESS, CITY, STATE, ZIP CODE

420 N UNIVERSITY ST
MURFREESBORO, TN 37120

DATE SURVEY COMPLETED

08/11/2010

ID PREFIX TAG

F441

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

ID PREFIX TAG

F441

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

ID PREFIX TAG

F441

The CNA that did not wash her hands after removing her gloves received education on proper hand washing on 8/11/10. In-services regarding proper hand hygiene were conducted by the DON for CNA's and Licensed nurses on 8/16/10, 8/17/10, 8/23/10 and 8/31/10. A quality assurance study will be conducted by the DON or her designee regarding observation of proper hand hygiene monthly for 3 months and then as directed by the Quality Assurance Committee.

8/31/10

This REQUIREMENT is not met as evidenced by:

Based on observation, facility policy review, and interview, the facility staff failed to wash the hands after providing incontinence care for one (#1) of
F 441 Continued from page 9

Thirty-three residents reviewed.

The findings included:

Observation on August 11, 2010, at 10:20 a.m., revealed a Certified Nursing Assistant (CNA) #1 providing incontinence care to resident #1, after an episode of fecal incontinence. Continued observation revealed after providing incontinence care to the resident, CNA #1 removed the gloves and without washing the hands, obtained clean linen from a linen cart located in the hallway. Continued observation revealed CNA #1 returned to the resident's room and placed the clean linen on the resident's bed. Continued observation revealed CNA #1 again exited the resident's room without washing the hands and opened the door to a linen closet, to obtain a pillow. Continued observation revealed there were no pillows located in the linen closet and CNA #1 proceeded to the elevator and pushed the button to go to the laundry to obtain a pillow.

Review of the facility's policy Handwashing revealed "...Hands must be washed with soap and water when...Before and after assisting resident with meals or toileting..."

Interview on August 11, 2010, at 10:35 a.m., with the Director of Nursing, in the nursing station, confirmed the hands are to be washed after providing incontinence care, and confirmed proper hand hygiene was not completed.

F 514 RES

The facility must maintain clinical records on each resident in accordance with accepted professional standards.
F 514

Continued from page 10

Standards and practices that are complete, accurately documented, readily accessible, and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, the facility failed to maintain a complete medical record for one (#12) of thirty-three residents reviewed.

The findings included:

Medical record review of resident #12's July 2010 physician's recitation orders revealed the resident was to receive Patanol (medication to treat allergic conjunctivitis) 0.1% opthalmic solution one drop to each eye twice a day.

Medical record review of the July 2010, Medication Record revealed the Patanol was circled as not administered on July 12 and 14, 2010. Medical record review of the Nurses's Medication Notes, located on the reverse side of the July 2010, Medication Record revealed no documentation why the Patanol was not administered on July 12 and 14, 2010.

Interview on August 9, 2010, at 2:50 p.m., with the Director of Nursing (DON), in the conference room, revealed when a medication was circled as
Continued from page 11

not administered, the reason for not administering the medication was to be documented on the reverse side of the Medication Record.

Interview on August 10, 2010, at 7:10 a.m., with Licensed Practical Nurse (LPN) #3 (nurse responsible for the administration of the Peptol on July 12, and 14, 2010), at the nursing station, confirmed the reason for not administering the Peptol was not documented on July 12, and 14, 2010.