### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>ID Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Precised by Full Regulatory or LSC Identifying Information)</th>
<th>ID Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Date Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>N727</td>
<td>(6) Pharmaceutical Services.</td>
<td>N727</td>
<td></td>
<td>4/30/10</td>
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<td></td>
<td>(b) All internal and external medications and preparations intended for human use shall be stored separately. They shall be properly stored in medicine compartments, including cabinets on wheels, or drug rooms.</td>
<td></td>
<td>1. The Treatment Cart #2 on the 300 Hall was immediately closed and locked on 04/13/10 at 11:30AM per the Quality Assurance Nurse. The Treatment Nurse was immediately notified and educated to keep Treatment Carts Locked and medications stored properly in the locked treatment cart by the Staff Development Nurse on 04/13/10.</td>
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<td></td>
<td>This Rule is not met as evidenced by: Type C Pending Penalty #7</td>
<td></td>
<td>2. All residents have the potential to be affected by this citation. No resident was identified to be affected by this citation. The Director of Nursing Services immediately checked all treatment and med carts on 04/13/10 at 11:30AM and no carts or medications were identified to be unsecured. Monitors for the Treatment Carts were put into place on 04/13/10 to assure compliance with medication storage.</td>
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<td></td>
<td>Tennessee Code Annotated 65-11-804(c)7 All internal and external medications and preparations intended for human use shall be stored separately. They shall be properly stored in medicine compartments, including cabinets on wheels, or drug rooms. Such cabinets or drug rooms shall be kept securely locked when not in use, and the key must be in the possession of the supervising nurse or other authorized persons then on duty.</td>
<td></td>
<td>3. Licensed Nursing staff in-serviced regarding Medication Storage Policy and Procedures on 04/13/10-04/16/10 per the Director of Nursing Services and the Staff Development Coordinator.</td>
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<td>This Rule is not met as evidenced by: Based on an observation and interview, it was determined the facility failed to secure medications in 1 of 18 (Station 2 Treatment Cart) medication storage areas.</td>
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<td>The findings included: Observations on the 300 hall on 04/13/10 at 11:25 AM, revealed the Station 2 Treatment Cart, which contained medications and supplies for treatments, was left unlocked and out of the view of the nurse.</td>
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<td>During an interview on the 300 hall on 04/13/10 at 11:30 AM the Nurse stated it was left unlocked because the Treatment Cart was being moved.</td>
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</tbody>
</table>
N 727
1200-8-6-.06(6)(b) Basic Services

(6) Pharmaceutical Services.

(b) All internal and external medications and preparations intended for human use shall be stored separately. They shall be properly stored in medicine compartments, including cabinets on wheels, or drug rooms.

This Rule is not met as evidenced by:
Type C Pending Penalty #7

Tennessee Code Annotated 68-11-804(c)7
All internal and external medications and preparations intended for human use shall be stored separately. They shall be properly stored in medicine compartments, including cabinets on wheels, or drug rooms. Such cabinets or drug rooms shall be kept securely locked when not in use, and the key must be in the possession of the supervising nurse or other authorized persons then on duty.

This Rule is not met as evidenced by:

Based on an observation and interview, it was determined the facility failed to secure medications in 1 of 18 (Station 2 Treatment Cart) medication storage areas.

The findings included:

Observations on the 300 hall on 4/13/10 at 11:25 AM, revealed the Station 2 Treatment Cart, which contained medications and supplies for treatments, was left unlocked and out of the view of the nurse.

During an interview on the 300 hall on 4/13/10 at
Continued From page 1

11:25 AM, the Quality Assurance (QA) Nurse stated, "She [treatment nurse] left it [treatment cart] open for the Mobile Wound Nurse... that nurse knew better [than to leave the cart unlocked]."

1200-8-6-12(1)(p) Resident Rights

(1) The nursing home shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservation of dignity, individuality and, to the extent medically feasible, independence. Residents and their families or other representatives shall be fully informed and documentation shall be maintained in the resident's file of the following rights:

(p) To have their records kept confidential and private. Written consent by the resident must be obtained prior to release of information except to persons authorized by law. If the resident lacks capacity, written consent is required from the resident's health care decision maker. The nursing home must have policies to govern access and duplication of the resident's record;

This Rule is not met as evidenced by:
Type C Pending Penalty #5

Tennessee Code Annotated 68-11-804(c)6
Each patient has a right to have the patient's personal records kept confidential and private.

This Rule is not met as evidenced by:

Based on observation and interview, it was
determined the facility failed to maintain confidentiality of a clinical record or failed to maintain a resident's privacy during pericare for 2 of 27 (Residents #1 and 13) sampled residents.

The findings included:

1. Observations on the 300 hall on 4/13/10 at 11:25 AM, revealed the Treatment Administration Record (TAR) book was left opened with Resident #1's TAR in public view.

   During an interview on the 300 hall on 4/13/10 at 11:26 AM, the Quality Assurance (QA) Nurse stated, "There's no explanation [for the TAR book to be left opened]..."

2. Observations in Resident #13's room on 4/13/10 at 9:25 AM, revealed Resident #13 was exposed from the waist down while Certified Nursing Assistants (CNA) #1 and CNA #2 provided pericare to Resident #13. Resident #13 was in a semi-private room in the bed that was beside the door. CNA #1 and CNA #2 failed to provide privacy by pulling the privacy curtain.

   During an interview in Resident #13's room on 4/13/10 at 9:25 AM, CNA #2 stated, "I usually pull the curtain I'm just nervous."