<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LTC IDENTIFYING INFORMATION)</th>
<th>ID</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 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
<td>The facility will maintain infection control practices to prevent the possible cross-contamination between residents receiving accu-check/glucometer machine blood testing. The facility will maintain infection control practices to prevent the possible cross-contamination between residents receiving accu-check/glucometer machine blood testing. The facility DON immediately re-in-serviced licensed nurses and witnessed return demonstrations. The 11/7 shift was re-in-serviced by the DON upon arrival to the building prior to taking report or using the glucometer. Nurses not on duty were re-in-serviced prior to using the glucometers by the DON, Staff Development Nurse, or RN Supervisor. New hires will be inserviced as part of orientation by the Staff Development Nurse or DON prior to being allowed to perform glucometer checks. Weekly monitoring will be conducted for three months. Monthly monitoring will continue for six months. Random audits will be done thereafter. The DON or her designate will be responsible.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>On July 25-27, 2011 an annual re-certification survey was completed. The facility was cited with an Immediate Jeopardy at F441 with a scope, and severity of a &quot;K&quot;. The facility's failure to maintain infection control practices to prevent the possible cross-contamination between residents, placed all diabetic residents receiving accu-check/glucometer machine blood testing in Immediate jeopardy. The facility will maintain infection control practices to prevent the possible cross-contamination between residents receiving accu-check/glucometer machine blood testing. The facility DON immediately re-in-serviced licensed nurses and witnessed return demonstrations. The 11/7 shift was re-in-serviced by the DON upon arrival to the building prior to taking report or using the glucometer. Nurses not on duty were re-in-serviced prior to using the glucometers by the DON, Staff Development Nurse, or RN Supervisor. New hires will be inserviced as part of orientation by the Staff Development Nurse or DON prior to being allowed to perform glucometer checks. Weekly monitoring will be conducted for three months. Monthly monitoring will continue for six months. Random audits will be done thereafter. The DON or her designate will be responsible.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Administrator and Director of Nursing (DON) were informed of the Immediate Jeopardy on July 25, 2011 at 4:15 PM, in the Administrator's office.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>An Allegation of Compliance (AOC) was received from the facility on 7/25/11 at approximately 5:00 PM with additional information received and accepted on 7/26/11 at approximately 7:30 AM.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
|      | The AOC the facility presented to the survey team documented the following corrective measures put in place:  
1. 7/25/11 (4:45 PM) All Licensed Nurses on duty were inserviced immediately on the policy and procedure for cleaning the glucometer. 10:45 PM  
- 11-7 nurses were inserviced on the policy and procedure with return demonstrations verified. 7/26/11 - 8:30 am Nurses were inserviced on the policy and procedure with return demonstrations verified. Inservices were conducted by the Director of Nurses.  
2. Each nurse inserviced verbalized to the Director of Nurses the correct procedure.  
3. New Hires will be inserviced by the Staff Development Nurse upon hire beginning |      |                                                                                                                 |                 |

 questões
### F 000

**Summary Statement of Deficiencies**

4. Licensed nurses employed at Dove will be inserviced by the Staff Development Nurse before they are allowed to do accu-checks and return demonstrations will be done. This applies to PRN (as necessary) nurses, New employees and Contracted nurses.

5. The Action Plan for the Quality Assurance Program will reflect Monitoring this process on a weekly basis for three months, monthly for six months and randomly. The DON (Director of Nursing) and Staff Development will be responsible.

During an interview on the 200 hall in front of Room 218 on 7/26/11 at 6:10 AM, Nurse #5 was asked if she had received an inservice on cleaning the glucometer. Nurse #5 stated, "...Yes, last night..."

During an interview on the 300 hall in front of Room 304 on 7/26/11 at 8:50 AM, Nurse #8 was asked when she was last inserviced on cleaning the glucometer. Nurse #8 stated, "...Inserviced on correct accu-check procedure this am [morning]..."

An exit conference was conducted with the Administrator, Director of Nursing and other department heads in the chapel on 7/27/11 at 6:30 PM. The facility staff were informed of the survey findings of the Immediate Jeopardy identified on 7/25/11 and the Immediate Jeopardy being removed as of 7/26/11 when the corrective action plan was validated by interview on all three shifts the 3-11 and 11-7 shifts on 7/25/11 and observation and interview on the 7-3 shift on

### F 000

The results of the review will be presented monthly to the Quality Assurance Committee. The QA Committee is composed of the Medical Director, Administrator, DON, Dietary Supervisor and Other Department Heads. The DON will present the findings to the QA Committee.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>Continued From page 2 7/26/11. The Immediate Jeopardy was effective from July 25, 2011 through 7/26/11. An acceptable Allegation of Compliance (AoC), which removed the Immediate Jeopardy, was received and corrective actions were validated on-site by observation and interview by the survey team on 7/26/11. Non-compliance of the Immediate Jeopardy tags continues at a scope and severity of a &quot;E&quot; level for monitoring of corrective actions. The facility is required to submit a plan of correction for all tags.</td>
<td>F 000</td>
</tr>
<tr>
<td>F 157</td>
<td>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident.</td>
<td>F 157</td>
</tr>
</tbody>
</table>

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 7971/11 Facility ID: TN7541 If continuation sheet: Page 3 of 37
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 157</td>
<td>Continued From page 3 and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</td>
<td>The facility will ensure that the physician is notified if a resident fails to have a bowel movement in three days and/or refuses to take scheduled medications.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</td>
<td>Resident #7 &amp; Resident #9 physicians were notified of resident's lack of bowel movement and refusal of ordered medication and continued to be notified as required.</td>
<td></td>
</tr>
<tr>
<td></td>
<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 ensure staff notified the physician when a resident failed to have a bowel movement in 3 days and/or refused to take scheduled medications as ordered for 2 of 19 (Resident #7 and 9) sampled residents.</td>
<td>Residents who reside in the facility who fail to have bowel movements (BM) in three days and/or refuse to take scheduled medications have the potential to be effected by the indicated citation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The findings included:</td>
<td>Current residents will be assessed for regular bowel patterns by the Patient at Risk Committee. The physician will be notified of residents who do not have a Bowel Movement for three days or residents who refuse to take scheduled medications.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Review of the facility &quot;Chronic Constipation/Impaction Prevention Plan&quot; documented, &quot;...Procedure 7. Physicians will be notified when orders need to be obtained or when the physician needs to be notified or a change in the resident's condition...&quot;</td>
<td>The PAR Committee consists of the DON, Dietary Manager, MDS Coordinator, Staff Development Coordinator, Social Worker, Activities Director, and the RN Supervisor. The PAR Committee will continue weekly to monitor residents with no Bowel Movement for three days until stable.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Medical record review for Resident #7 documented an admission date of 1/26/11 with diagnoses of Hypertension, Cerebrovascular Accident with Left Side Weakness and Paralysis Left Upper Extremity, and Diabetes Mellitus. The Activities of Daily Living (ADL) record</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td>TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID</td>
</tr>
<tr>
<td>----</td>
<td>-----</td>
<td>-------------------------------------------------</td>
<td>----</td>
</tr>
<tr>
<td>F157</td>
<td>Continued From page 4 documented the following: March 2011 a. 3/15/11 through 3/21/11 (7 days) with no bowel movement April 2011 a. 4/3/11 through 4/25/11 (23 days) with no bowel movement May 2011 a. 5/1/11 through 5/6/11 (6 days) with no bowel movement b. 5/10/11 through 5/14/11 (5 days) with no bowel movement c. 5/27/11 through 5/31/11 (5 days) with no bowel movement June 2011 a. 6/8/11 through 6/18/11 (10 days) with no bowel movement. Physician's order dated 4/13/11 to present documented, &quot;...Simvastatin 20 mg [milligrams] po [by mouth] q [every] hs [hour of sleep]...Mirtazapine 30 mg po q hs...&quot; PSYCHO-PHARMACOLOGICAL RECORD dated April 2011 documented: April 14, 18-21, 25-29 &quot;...refusal Mirtazapine 30 mg...refusal Simvastatin 20 mg...&quot; PSYCHO-PHARMACOLOGICAL RECORD dated May 2011 documented May 1-3, 5-7, 9-13, 16-20, 23, &quot;...refusal Simvastatin 20 mg...&quot; There was no documentation the physician was notified of Resident #7's lack of bowel movement or the resident's refusal of ordered medication. 3. Medical record review for Resident #9 documented an admission date of 2/22/11 with diagnoses of Anemia, Disseminated Metastatic Disease in the Abdomen and Pelvis and Ovarian Cancer, Atrial Fibrillation and Hypertension. The F157 The DON or Designee will audit ADL's weekly for four weeks, monthly for two additional months, and quarterly for three quarters. The nurses will be re-in-serviced by the DON or Designee on physician notification related to lack of BM for three days or refusal of scheduled medications. (In-service Dates 7/28, 7/30, 8/10) The CNA's will be re-in-serviced by the DON or Designee to notify nurses when residents do not have a bowel movement for three days. (In-service Dates 7/28, 7/30, 8/10) The DON will present the PAR Committee results in the monthly Quality Assurance Meeting. The QA Committee consists of the Medical Director, Administrator, DON, Dietary Supervisor, and other Department Heads. The Administrator will monitor to ensure compliance. Compliance Date: 8-22-11</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
F 157 Continued From page 5
ADL record documented the following:
April 2011
a. 4/20/11 through 4/23/11 (4 days) with no bowel movement
May 2011
a. 5/1/11 through 5/7/11 (7 days) with no bowel movement.

4. During an interview in the Director of Nursing (DON) office on 7/27/11 at 8:05 AM, the DON confirmed there was no documentation the physician was notified. The DON stated, "...Expect the physician to be notified if no BM [bowel movement] in three days...I see no notification of the physician concerning bowel movement...I see no notification of the physician for refusal of medications in April and May..."

F 221 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RERAINTS

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

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 obtain consent and assess for physical restraints for 2 of 2 (Resident #5 and 8) sampled residents with physical restraints.

The findings included:
1. Review of the facility's "RESTRAINT GUIDELINES AND MONITORING" policy
<table>
<thead>
<tr>
<th>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-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 221</td>
<td>Continued From page 6 documented, &quot;Physical restraints or safety devices are used to enable and promote greater functional independence of the resident after...discussion with the resident, family member or legal representative...Restraint assessments must be completed prior to use of restraints...Procedure 1. Restraints may be used when the following criteria is met...b. the restraint evaluation (GP-208) is completed to ensure the least restrictive device is used and the consent of the resident and/or family is documented...2. After completion of the evaluation and review of the PAR [Physician Restraint Review and Reduction] committee, the restraint may be applied as recommended...&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 221</td>
<td><strong>F221</strong> The Facility will ensure that physical restraints will not be used except for treatment of medical symptoms which have been assessed, ordered by the physician and consented to by the responsible party.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Resident #5 &amp; Resident #8 have been assessed and have consents for physical restraints.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Residents who require physical restraints have the potential to be affected.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The DON and or Designee reinserviced the nurses on restraint protocol on 7/28/11, 7/30/11, 8/10/11.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Documentation will be reviewed by the DON or Designee to verify residents with restraints have been assessed and indicated consents are completed. The Facility Practices Review Committee will monitor residents to ensure the restraint policy is followed. Care plans and care giver guides will be updated by the PAR committee weekly.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Medical record review for Resident #5 documented an admission date of 4/21/11 with diagnoses of After Care of Traumatic Fracture Hip, Chronic Obstructive Pulmonary Disease, Hypertension and Depressive Disorder. Review of a physician's order dated 4/22/11 to present documented, "Self release seatbelt to wheelchair when oob [out of bed] to reduce potential of falls due to poor standing balance and unsteady gait. Check q [every] 30 minutes. Release, reposition, exercise q 2 hrs [hours] and PRN [as needed]." Review of the care plan dated 5/4/11 documented, "Restraint: High risk for side effects of restraint n/a [related to] self release belt to reduce potential of falls due to poor standing balance & [and] unsteady gait." Review of the "MEDICATION ADMINISTRATION RECORD" dated June 2011 documented the self release seatbelt in place on all three shifts for every day in June 2011. There was no documentation of a restraint
<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>
<th>(xx) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 221</td>
<td>Continued From page 7 assessment or consent for restraints from 4/22/11 to present. Observation in Resident #5's room on 7/28/11 at 12:55 PM, revealed Resident #5 seated in her wheelchair with the self release seat belt on. During an interview in the Director of Nursing (DON) office on 7/27/11 at 8:45 AM, when asked about Resident #5's self release belt the DON stated &quot;...coded as a restraint, anytime you put a seat belt on someone, you would do a restraint assessment; this chart doesn't have one. It should have a restraint assessment and a consent signed...no evaluation for restraint nor consent.&quot;</td>
<td>F 221</td>
<td>The DON or Designee, as members of the Facility Practices Review committee, a subcommittee of the QA committee, will audit restraint assessments and consents to verify they are complete. Audits will be completed monthly and reported to the Quality Assurance Committee for review and further recommendation. The DON or designee will present the review monthly for three months to the Quality Assurance Committee. The QA Committee consists of the Medical Director, Administrator, DON, Director of Therapy, Food Service Supervisor, Social Worker, Activity Director and other Department Heads. The Director of Nursing is responsible for overall monitoring and ongoing compliance.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Medical record review for Resident #8 documented an admission date of 4/9/10 with a readmission date of 5/17/10 with diagnoses of Schizophrenia, Dementia, Hypertension, Chronic Back Pain and Muscle Spasms. Review of a physician's order dated 5/12/11 to present documented, &quot;Seat belt while cob and up in wheelchair to reduce risks of fall due to postural instability and poor standing balance. Check 30 minutes, release, and exercise q 2 hrs and PRN.&quot; Review of the Minimum Data Set dated 6/27/11 documented, &quot;Restraints in chair/out of bed: other...2. Used daily.&quot; Review of the care plan dated 4/20/11 documented, &quot;Restraint: Moderate risk for restraint use r/t use of seat belt in w/ [wheelchair]. There was no documentation of a restraint assessment or consent for restraints from 5/12/11 to present.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**F 221** Continued From page 8

Observations in Resident #8's room on 7/25/11 at 10:10 AM and 3:40 PM, revealed Resident #8 seated in her wheelchair with the seat belt on. When asked if she could release her seat belt, Resident #8 made several unsuccessful attempts and stated "No".

Observations in the second floor dayroom on 7/26/11 at 7:06 AM, revealed Resident #8 seated in her wheelchair with the seat belt on. When asked if she could release her seat belt, Resident #8 stated "No".

During an interview in the chapel on 7/27/11 at 10:52 AM, when asked what the facility policy is for restraints the DON stated "...use the Restraint Evaluation Form that lists the alternatives tried..." When asked about the consent and assessment for restraints for Resident #8, the DON stated "...it's not on here..."

During an interview in 2nd floor hallway on 7/27/11 at 11:07 AM, when asked about Resident #8's seat belt Nurse #7 stated, "She cannot release it...it is a restraint to keep her from falling."

**F 278**

483.20(g) - (j) ASSESSMENT
ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the
Continued From page 9
assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

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 Minimum Data Set (MDS) was accurate for oxygen therapy and fails for 2 of 19 (Resident #9 and 16) sampled residents.

The findings included:

1. Medical record review for Resident #9 documented an admission date of 2/22/11 and a readmission date of 2/28/11 with diagnoses of Anemia. Disseminated Metastatic Disease in the Abdomen and Pelvis and Ovarian Cancer, Atrial Fibrillation and Hypertension.

Review of the physician's orders dated 2/28/11 to
<table>
<thead>
<tr>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
</tr>
</thead>
</table>
| F 276  |     | Continued From page 10 present documented, "...O2 [oxygen] @ [at] 2 LPM [liters per minute] BNC [by nasal cannula] to keep O2 > [greater] 92% [percent]..."
|        |     | Review of the "RESPIRATORY ADMINISTRATION RECORD" dated June 2011 documented June 1 through 30, O2 @ 2 LPM BNC to keep O2 > 92%. Review of the quarterly MDS dated 5/27/11 "...Section O 0100C2: Oxygen therapy" revealed no documentation that oxygen was used by the resident. The facility failed to accurately complete the MDS to reflect physician orders for O2.

<table>
<thead>
<tr>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 276</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Observation in Resident #9's room on 7/25/11 at 10:05 AM and 7/28/11 at 8:15 AM, revealed Resident #9 wearing oxygen per nasal cannula at 2 liters per minute.

2. During an interview in the Director of Nursing (DON) office on 7/27/11 at 7:25 AM, the DON stated, "...Yes, she is on oxygen and has been...the MDS [6/7/11] does not have Oxygen checked..."

3. Medical record review for Resident #16 documented an admission date of 9/16/10 and a readmission date of 4/25/11 with diagnoses of Acute Renal Failure, Chronic Obstructive Pulmonary Disease, Bipolar and Hypertension. Review of the MDS with an Assessment Reference Date of 7/19/11 revealed no documentation of a fall in the past 31-180 days. Review of the nurses' notes dated 7/11/11 documented, "...found on the floor between foot of bed and wheelchair..."

The facility failed to accurately complete the MDS.
The facility will ensure that the comprehensive care plan will be revised as needed to address changes in medication and falls.

Residents #5, 7, and 11
Care plans have been updated & reflect the current resident status.

Current residents were assessed for care plan accuracy to reflect changes in psychoactive medications and falls by the DON and/or designee.
The DON and/or Designee did inservices on 7/28/11, 7/30/11, and 8/10/11.

The MDS coordinator will audit residents with psychoactive medications and falls to ensure they are addressed on the care plans. The weekly Patient at Risk Committee will monitor the care plan to ensure changes are addressed.
Continued From page 12

The findings included:

1. Review of the facility's "CARE PLAN" policy documented, "...The comprehensive care plan for each resident includes the measurable goals and timetables to meet a resident's medical, nursing, and psychosocial needs that are identified in the comprehensive assessment (RAI [Resident Assessment Instrument]). The plan is developed in coordination with the attending physician's plan of medical care and is reviewed as necessary, but at least quarterly and when there is a change in the resident's condition, by all professional personnel involved in the care of the resident..."

   Review of the facility's "FALLS POTENTIAL AND RISK REDUCTION PROTOCOL" policy documented, "...The care plan should be updated after a fall to address the most recent cause of the fall."

2. Medical record review for Resident #5 documented an admission date of 4/21/11 with diagnoses of After Care of Traumatic Fracture Hip, Chronic Obstructive Pulmonary Disease, Hypertension and Depressive Disorder. Review of the physician order dated 4/21/11 to present documented, "...Risperdal 2 mg [milligrams] po [by mouth] bid [twice a day]...Ativan 0.5 mg po q [every] 8 hrs [hours] PRN [as necessary]...Effexor XR [extended release] 150 mg po daily..."

   Review of the care plan dated 5/4/11 revealed no documentation to address psychoactive medications.

   The MDS Coordinator or designee, as members of the Record of Care committee will present the audit results and action plans to the DON for the QA Committee monthly for three months and quarterly for three quarters. The QA committee consists of the Medical Director, Administrator, DON, Director of Therapy, Social Worker, Food Service Supervisor, Activities Director, and other Department Heads. The Administrator and DON will ensure compliance.

   Completion Date: 8-22-11
F 280 Continued From page 13

During an interview in the Director of Nursing (DON) office on 7/27/11 at 8:45 AM, the DON was asked to review the care plan for psychoactive medications. The DON stated, "...She [Resident #5] should have a care plan for psychoactive medications, I don't see it..."

3. Medical record review for Resident #7 documented an admission date of 1/26/11 with diagnoses of Hypertension, Cerebrovascular Accident with Left Side Weakness and Paralysis Left Upper Extremity, and Diabetes Mellitus. Review of the physician order dated 4/13/11 to present documented, "...Mirtazapine 30 mg po qhs [hour of sleep],..."

Review of the care plan dated 4/25/11 revealed no documentation to address psychoactive medications.

During an interview in the Director of Nursing (DON) office on 7/27/11 at 9:05 AM, the DON was asked to review Resident #7's care plan for psychoactive medications. The DON stated, "...I see no care plan for psychoactive medications..."

4. Medical record review for Resident #11 documented an admission date of 11/26/10 and a readmission date of 4/29/11 with diagnoses of Muscle Weakness, Late Effect Cerebrovascular Disease, Anemia, Hypertension, Diabetes, Congestive Heart Failure, Osteoarthritis, Coronary Atherosclerosis, and Hepatic Cirrhosis. Review of the nurses’ notes dated 5/7/11, 5/20/11, and 5/25/11 documented a fall. Review of the care plan dated 5/13/11 did not document any new interventions for these falls. Review of a physician's telephone order dated 6/31/11 documented, "...Pt [patient] is to have
### Summary Statement of Deficiencies

**F 283**

Continued From page 14

landing strips to bedside while in bed for safety to prevent risk for fall..." This intervention was not documented on the care plan.

Observations in Resident #11's room on 7/25/11 at 10:10 AM, 2:10 PM, and 5:05 PM, and on 7/26/11 at 8:10 AM and 3:30 PM, revealed Resident #11 lying in bed with no landing strips to bedside.

During an interview in the Minimum Data Set (MDS) office on 7/27/11 at 8:55 AM, Nurse #6 confirmed new interventions should be on the care plan and stated, "...I do not see anything..." Nurse #6 confirmed the landing strips should have been on the care plan and stated, "I may have missed the order, I have not seen any landing strips in his [Resident #11] room.

**F 283**

483.20(f)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS

When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to develop a recapitulation of the resident's stay for 2 of 3 (Resident #17 and 19) sampled residents who had been discharged.

**F 283**

The facility will ensure that Interdisciplinary Discharge Summaries will include recapitulation of the resident's stay & are completed when residents are discharged.

Residents #17 and #19 no longer reside at this facility.

Residents who discharge from the facility have the potential to be affected by the indicated citation.

Medical records will break down discharge charts. The Medical Records Nurse will audit weekly for four weeks and monthly for two months will follow. Audit results will be reviewed with the Record of Care Committee, a subcommittee of the QA committee.

Medical records will notify the DON and administrator if audits reveal that discharge summaries have not been completed. Charts that require summaries will be brought to the stand up meeting weekly by the medical records nurse.

The DON and/or Designee did inservices on 7/28/11, 7/30/11, and 8/10/11.
**F 283** Continued From page 15

The findings included:

1. Medical record review for Resident #17 documented an admission date of 4/2/11 with diagnoses of Respiratory Failure, Chronic Obstructive Pulmonary Disease, Cerebrovascular Accident, Transient Ischemic Attacks and Urinary Tract Infection. Review of a physician’s order dated 5/13/11 documented, “May D/C [discharge] home in AM...” There was no recapitulation of the resident's stay documented.

2. Medical record review for Resident #19 documented an admission date of 3/15/11 with diagnoses of Deep Vein Thrombosis, Hypertension and Cellulitis. Review of a physician’s order dated 5/19/11 documented, “...May D/C Home...” There was no recapitulation of the resident's stay documented.

3. During an interview in the Social Services office on 7/27/11 at 2:05 PM, the Director of Nursing confirmed that there was no recapitulation documented for Resident #17 or 19.

**F 315**

483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

Based on the resident’s comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident’s clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder

<table>
<thead>
<tr>
<th>ID</th>
<th>PREMIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 283</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 315</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Cont. 283)
Reviews of the audits and action plans will be presented to the QA committee for further recommendation. Medical Records and DON are responsible for overall monitoring and ongoing compliance.

Completion Date: 8-22-11

F 315
The facility will ensure that there is a medical diagnosis to justify the use of Foley catheters.

Resident #15 chart has been reviewed and updated to reflect appropriate documentation related to Foley catheter.

Residents who have Foley catheters have the potential to be affected by the indicated citation.

The DON and/or Designee audited resident charts with Foley catheters to assure the appropriate diagnosis is present. New admissions with a Foley catheter will be assessed by nursing to ensure the catheter is removed as indicated based on physician order if there is not justifiable medical diagnosis.

The DON re-in-serviced the staff on this practice on 8/10/11, 8/15/11, 8/18/11 and the Staff Development will in-serviced during orientation.
### Summary of Deficiencies

**ID** | **Prefix** | **Tag** | **Summary Statement of Deficiencies** (Each deficiency must be preceded by full regulatory or LSO identifying information) |
---|---|---|---|
F 315 | | | Continued From page 16 function as possible.

This REQUIREMENT is not met as evidenced by:

- Based on medical record review, observation, and interview, it was determined the facility failed to ensure that there was a medical diagnosis to justify the use of a Foley catheter for 1 of 5 (Resident #15) sampled residents with an indwelling Foley catheter.

The findings included:

- Medical record review for Resident #15 documented an admission date of 5/29/10 with a readmission date of 5/18/11 with diagnoses of Chronic Hepatitis, Chronic Respiratory Failure, Continuous Mechanical Ventilator, Tracheostomy Status, Gastrostomy Status, Diabetes, and Obstructive Pulmonary Disease, and Congestive Heart Failure.

Review of the July 2011 physician’s orders signed 7/12/11 documented, "...Foley catheter care q [every] shift...Change foley [indwelling] catheter q month..."

Observations in Resident #15’s room on 7/25/11 at 10:20 AM and 7/27/11 at 10:00 AM, revealed Resident #15 lying in bed with an indwelling catheter to a bedside bag.

During an interview in the Social Worker office on 7/27/11 at 1:35 PM, the Director of Nursing (DON) was unable to locate a diagnosis for the indwelling Foley catheter. The DON stated, "[Resident #15] has the catheter due to knee immobilizers, they get saturated with urine..." and

**ID** | **Prefix** | **Tag** | **Provider’s Plan of Correction** (Each corrective action should be cross-referenced to the appropriate deficiency) |
---|---|---|---|
F 315 | | | The DON or Designee will conduct the audit weekly for four weeks and monthly for two months, and quarterly for three quarters. Results will be reported to the monthly Quality Assurance Committee. The Quality Assurance Committee consists of the Medical Director, Administrator, DON, MDS, SDC, SW, Activity Director and other Department Heads. The Administrator and DON will monitor for compliance.

Completion Date: 8-22-11
<table>
<thead>
<tr>
<th>ID</th>
<th>PREVIOUS TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LCD IDENTIFYING INFORMATION)</th>
<th>ID</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 315</td>
<td>Continued From page 17, confirmed this did not justify an indwelling catheter.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 323</td>
<td><strong>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</strong> 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.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>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 develop new interventions, revise and update the care plan, or follow the physician order for interventions for 1 of 5 (Resident #11) sampled residents with falls. The findings included: Review of the facility's &quot;FALLS POTENTIAL AND RISK REDUCTION PROTOCOL&quot; policy documented, &quot;...The care plan should be updated after a fall to address the most recent cause of the fall.&quot; Medical record review for Resident #11 documented an admission date of 11/26/10 and a readmission date of 4/29/11 with diagnoses of Muscle Weakness, Late Effect Cerebrovascular Disease, Anemia, Hypertension, Diabetes, Congestive Heart Failure, Osteoarthritis, Coronary Atherosclerosis, and Hepatic Cirrhosis.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 315</td>
<td>F323 The facility will ensure that the care plan is updated to reflect the facility's fall potential and risk reduction protocol policy as it applies to the cause of a fall with the newly developed interventions, revisions, updates and/or physician orders. Resident #11 was reassessed by Therapy with interventions, revisions, and physician orders implemented and care planned. Residents who have falls have the potential to be affected by the indicated citation. The DON, MDS coordinator, or designee will complete an audit of falls from July to current to ensure interventions and care plans have been updated. The DON and/or Designee did inservices on 7/28/11, 7/30/11, and 8/10/11.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completion Date: 8-22-11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></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-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td>COMPLETION DATE</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td>----------------</td>
<td></td>
</tr>
</tbody>
</table>
| F 323        | Continued From page 18  
Review of the nurses' notes dated 5/7/11, 5/20/11, and 5/26/11 documented a fall.  
Review of the care plan dated 5/18/11 did not document any new interventions for these falls.  
Review of a physician's telephone order dated 5/31/11 documented: "...Pt [patient] is to have landing strips to bedside while in bed for safety to prevent risk for fall..." This intervention was not documented on the care plan.  
Observations in Resident #11's room on 7/25/11 at 10:10 AM, 2:10 PM, and 5:05 PM, and on 7/27/11 at 8:10 AM and 3:30 PM, revealed Resident #11 lying in bed with no landing strips to bedside.  
During an interview in the Minimum Data Set (MDS) office on 7/27/11 at 8:55 AM, Nurse #6 confirmed new interventions should be on the care plan and stated, "...I do not see anything..." Nurse #6 confirmed the landing strips should have been on the care plan and stated; "I may have missed the order, I have not seen any landing strips in his [Resident #11] room. | F 323 | Audits will be completed by the DON or Designee, as members of the Facility Practices Review committee, a subcommittee of the QA committee weekly for four weeks, monthly for two months and quarterly for three quarters. These findings will be reported to the Quality Assurance committee.  
The QA Committee will review and make recommendations as needed.  
The Administrator and DON will monitor for compliance. | 8-22-11 |
| F 332        | 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE | F 332        | The facility must ensure that it is free of medication error rates of five percent or greater. | 8-22-11 |
| SS=D         | This REQUIREMENT is not met as evidenced by:  
Based on review of the "MED-PASS COMMON INSULINS" provided by the American Society of Consultant Pharmacists, medical record review, observation, and interview, it was determined the | | | |
F 332 Continued From page 19

Facility failed to ensure 1 of 11 (Nurse #1) nurses administered medications during 1 of 3 (5-11 shift) shifts with a medication error rate of less than 5 percent (%). A total of 3 errors were observed out of 40 opportunities, resulting in a medication error rate of 7.5%.

The findings included:

1. Review of the "MED-PASS COMMON INSULINS: Pharmacopeiels, Compatibility, and Properties" provided by the American Society of Consultant Pharmacists for typical dosing administration of insulins related to meals documented, "Humulin R [Regular]...ONSET [In Hours Unless Noted]... 0.5 [1/2 hour] - [to] 1 [hour]... TYPICAL ADMINISTRATION/COMMENTS...30 MINUTES PRIOR TO MEALS..."

2. Medical record review for Resident #13 documented an admission date of 8/17/10 with diagnoses of Diabetes Mellitus (DM), Muscle Weakness, Dysrhythmic Disorder, Chronic Hepatitis, Depression and Anxiety. A physician’s order dated 7/8/11 documented, "...ACCUCHECK BEFORE MEALS AND BEDTIME W [with]/SSI [sliding scale insulin] NOVOLIN R SC [subcutaneously] [may use Novolin R and Humulin R interchangeably]: 0-150= [equals] 0 UNITS, 151-200=2 UNITS, 201-300=4 UNITS, 251-300=6 UNITS, 301-350=8 UNITS, 351-400=10 UNITS, > [greater than] 401=12 UNITS AND RECHECK IN 2 HOURS, IF STILL >401, NOTIFY MD [medical doctor]/NP [nurse practitioner]..."

Observation in Resident #13’s room on 7/25/11 at 3:45 PM, revealed a blood sugar result of 303 per
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 332</td>
<td>Continued from page 20</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>accu-check machine requiring 8 Units of Novolin R insulin. Observations in Resident #1's room on 7/25/11 at 4:35 PM, revealed Nurse #1 administered Humulin R 8 Units to Resident #13. The resident took her first bite of food at 5:38 PM. The failure to administer the insulin and provide the meal within 30 minutes resulted in medication error #1</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>3. Medical record review for Random Resident (RR) #1 documented an admission date of 5/26/11 with diagnoses of DM, Chronic Obstructive Pulmonary Disease (COPD), Muscle Weakness, Hypertension, Hypothyroidism, and Hemolytic Anemia. A physician's order dated 7/1/11 documented, &quot;...Accuchecks AC [before meals] &amp; [and] HS [bedtime] w/SSI Humulin R SC [may use Novolin R and Humulin R interchangeably]: 1-150=0 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units &gt; [greater] than 400=12 units and recheck in 2 hrs [hours]. If still &gt; than 400, notify MD/NP.&quot;</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Observation in RR #1's room on 7/25/11 at 3:55 PM, revealed a blood sugar result of 193 per accu-check machine requiring Novolin R 2 Units. Observations in RR #1's room on 7/25/11 at 5:24 PM, revealed Nurse #1 administered Novolin R 2 units SC. RR #1 had not received a meal tray or food at 5:40 PM. The failure to administer the insulin and deliver the meal within 30 minutes resulted in medication error #2.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>4. Medical record review for RR #2 documented an admission date of 6/10/11 with diagnoses of DM, Gastrointestinal Hemorrhage, Encephalopathy, Hypertension, Peripheral</strong></td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td>TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
</tr>
<tr>
<td>-----</td>
<td>-----</td>
<td>---------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>F 332</td>
<td>Continued From page 21 Vascular Disease (PVD) and Atrial Fibrillation. A physician's order dated 7/8/11 documented, &quot;...Accuchecks AC &amp; HS w/SSI Humulin R SC [may use Novolin R and Humulin R interchangeably]... 151-200=2 units; 201-250=4 units; 250-300=10 units &gt; than 401, notify MD/INP...&quot; Observation in RR #2's room on 7/25/11 at 4:00 PM, revealed a blood sugar result of 153 per accu-check machine requiring 2 Units of Novolin R insulin. Observations in RR #2's room on 7/25/11 at 5:40 PM, revealed Nurse #1 administered Novolin R 2 units. RR #2 had not received a meal tray or food at 6:40 PM. The failure to administer the insulin and deliver the meal within 30 minutes resulted in medication error #3. 5. During an interview in the Social Services office on 7/27/11 at 4:00 PM, the Director of Nursing confirmed rapid acting insulin (Regular insulin) should be administered within 30 minutes of a meal, and stated, &quot;I am working on an action plan for the diabetics who get sliding scale insulin to be fed first, so insulin won't be early.&quot;</td>
<td>F 332</td>
</tr>
<tr>
<td>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</td>
<td>The facility must ensure that residents are free of any significant medication errors.</td>
<td>F 333</td>
</tr>
</tbody>
</table>
F 333

Continued From page 22

observation, and staff interview, it was
determined that the facility failed to ensure 1 of 5
(Nurse #1) nurses administered insulin without
significant medication errors for 3 of 10 (Resident
#13, Random Resident (RR) #1 and 2) residents
requiring insulin administration.

The findings included:

1. Review of the "MED-PASS COMMON
INSULINS: Pharmacokinetics, Compatability, and
Properties" provided by the American Society of
Consultant Pharmacists for typical dosing
administration of insulins related to meals
documented, "Humulin R [Regular]...ONSET [In
Hours Unless Noted]... 0.5 [1/2 hour] - [to] 1
(hour)... TYPICAL
ADMINISTRATION/COMMENTS...30 MINUTES
PRIOR TO MEALS..."

2. Medical record review for Resident #13
documented an admission date of 8/17/10 with
diagnoses of Diabetes Mellitus (DM), Muscle
Weakness, Dysrhythmic Disorder, Chronic
Hepatitis, Depression and Anxiety. A physician's
order dated 7/8/11 documented, "...ACCUCHECK
BEFORE MEALS AND BEDTIME W [with]/SSI
[sliding scale insulin] NOVOLIN R SC
[subcutaneously] [may use Novolin R and
Humulin R interchangeably]: 0-150= [equals] 0
UNITs, 151-200=2 UNITS, 201-300=4 UNITS,
251-300=6 UNITS, 301-350=8 UNITS, 351-400=
10 UNITS, > [greater than] 401=12 UNITS AND
RECHECK IN 2 HOURS, IF STILL >401, NOTIFY
MD [medical doctor]/NP[nurse practitioner]...

Observation in Resident #13's room on 7/25/11 at
3:45 PM, revealed a blood sugar result of 303 per
<table>
<thead>
<tr>
<th>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>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 333</td>
<td>Continued From page 23 accu-check machine requiring 6 Units of Novolin R Insulin. Observations in Resident #13's room on 7/25/11 at 4:35 PM, revealed Nurse #1 administered the insulin to Resident #13. The resident took her first bite of food at 5:38 PM. The failure to administer the insulin and provide the meal in 30 minutes resulted in a significant medication error.</td>
<td>F 333</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Medical record review for Random Resident (RR) #1 documented an admission date of 5/26/11 with diagnoses of DM, Chronic Obstructive Pulmonary Disease (COPD), Muscle Weakness, Hypertension, Hypothyroidism, and Hemolytic Anemia. A physician's order dated 7/1/11 documented, &quot;...Accuchecks AC [before meals] &amp; [and] HS [bedtime] w/ [with]/SSI Humulin R SC [may use Novolin R and Humulin R interchangeably]: 1-150=0 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units &gt; [greater] than 400=12 units and recheck in 2 hrs [hours]. If still &gt; than 400, notify MD/NP...&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Observation in RR #1's room on 7/25/11 at 3:55 PM, revealed a blood sugar result of 153 per accu-check machine. Observations in RR #1's room on 7/25/11 at 5:24 PM, revealed Nurse #1 administered Novolin R 2 units. RR #1 had not received a meal tray or food at 6:40 PM. The failure to administer the insulin and deliver the meal in 30 minutes resulted in a significant medication error.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Medical record review for RR #2 documented an admission date of 6/10/11 with diagnoses of DM, Gastrointestinal Hemorrhage, Encephalopathy, Hypertension, Peripheral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID</td>
<td>PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td>COMPLETION DATE</td>
</tr>
<tr>
<td>----</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
<td>----</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
</tbody>
</table>
| F 333 | Continued From page 24  
Vascular Disease (PVD) and Atrial Fibrillation. A physician's order dated 7/8/11 documented, "...Accuchecks AC & HS w/SSI Humulin R SC [may use Novolin R and Humulin R interchangeably]. 151-200=2 units; 201-250=4 units; 250-300=10 units > than 401, notify MD/NP...."
Observation in RR #2's room on 7/25/11 at 4:00 PM, revealed a blood sugar result of 153 per accu-check machine. Observations in RR #2's room on 7/25/11 at 5:40 PM, revealed Nurse #1 administered Novolin R 2 units. RR #2 had not received a meal tray or food at 6:40 PM. The failure to administer the insulin and deliver the meal in 30 minutes resulted in a significant medication error.

5. During an Interview in the Social Services office on 7/27/11 at 4:00 PM, the Director of Nursing confirmed rapid acting insulin (Regular insulin) should be administered within 30 minutes of a meal, and stated, "I am working on an action plan for the diabetics who get sliding scale insulin to be fed first, so insulin won't be early."

| F 371 | 483.35(1) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY |

F 371  
The facility will ensure that the temperature of hot foods on the steam table is at or above 135 degrees Fahrenheit.  
No specific resident was identified. Residents who receive hot foods from the facility dietary department are receiving foods at the proper temperature.  
Residents who receive hot foods from the facility have the potential to be affected. Temperatures were verified by the Maintenance Director on the steam table for to ensure the thermostats were working properly. Dietary staff have been re-in-serviced on the requirement for hot food temperatures by the Administrator, DON, and/or Designee. Dietary staff will continue to monitor temperatures for hot food served to ensure appropriate temperatures. Inservice Dates: 8/10/11, 8/13/11, 8/15/11

If continuation sheet Page 25 of 37
**F 371 Continued From page 25**

This REQUIREMENT is not met as evidenced by:

Based on policy review, observation, and interview, it was determined the facility failed to maintain the temperature of hot foods on the steam table at or above 135 degrees Fahrenheit (F) for 3 of 8 foods on the tray line in the first floor dining room and for 1 of 5 foods on the second floor tray line.

The findings included:

1. Review of the facility's "FOOD TEMPERATURES" policy documented, "...Keep the temperature of hot foods no less than 135 [symbol for degree] F (or according to individual state regulations) during tray assembly..."

2. Observations in the first floor dining room on 7/28/11 at 11:30 AM, revealed the following:
   a. Chopped pork chops-110 degrees F
   b. Pureed greens-100 degrees F
   c. Pureed pinto beans-100 degrees F

   During an interview in the first floor dining room on 7/28/11 at 12:00 PM, the Dietary Manager stated, "Expect them [staff] to reheat, will reheat them now."

3. Observations in the second floor dining room on 7/28/11 at 11:55 AM, revealed Dietary Worker #1 then started serving the trays without reheating.

Observations in the second floor dining room on 7/28/11 at 12:35 PM, revealed the following:

Pureed pork chops-130 degrees F, and was not
<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>F 371</td>
<td>Continued From page 26 reheated. During an interview in the second floor dining room on 7/28/11 at 12:45 PM, Dietary Worker #2 stated, &quot;Pureed meat was 130 [degrees F], that is ok.&quot;</td>
<td>F 371</td>
<td></td>
</tr>
<tr>
<td>F 431</td>
<td>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</td>
<td>F 431</td>
<td></td>
</tr>
</tbody>
</table>

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the...
<table>
<thead>
<tr>
<th>ID PREX Tag</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREX 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 431</td>
<td>Continued From page 27 quantity stored is minimal and a missing dose can be readily detected.</td>
<td>F 431</td>
<td>The facility will ensure that medications are dated as required, not stored past their expiration date, and medications are not left unattended in carts or medication storage areas. The DON and/or Designee audited Medication carts and Medication rooms on July 28, 2011, to ensure expired medications were not present. The Pharmacy Consultant will complete a facility audit of carts and medication rooms by August 19. The Staff was re-in-serviced on July 28, and August 10 by the DON and or designee, on expired medications and unattended carts and medication storage areas. The Pharmacy Consultant will complete random audits monthly of Med Carts and Med Rooms. The results will be given to the DON as a member of the Facility Practices Review committee, a subcommittee of the QA committee. Results &amp; action plans where indicated will be reported to the Quality Assurance Committee.</td>
<td></td>
</tr>
</tbody>
</table>

The findings included:

1. Observations at the Upper 200 half medication cart on 7/26/11 at 6:15 AM, revealed 1 insulin vial not labeled with an open date. Observations at the Lower 200 half medication cart on 7/27/11 at 11:00 AM, revealed 1 Lorazepam medication pump card with an expiration date of 3/2011. Observations at the Upper 200 half medication cart on 7/27/11 at 11:10 AM, revealed 1 insulin bottle not labeled with an open date. Observations at the Upper 300 half medication cart on 7/27/11 at 11:30 AM, revealed 2 insulin bottles not labeled with an open date. Observations in the 200 half medication room on 7/27/11 at 3:35 PM, revealed Nurse #1 unlocked and opened the door to the medication room, the surveyor entered the room. Nurse #1 left the medication room, and the medications in this room were out of sight of Nurse #1.

Completion Date: 8-22-11
<table>
<thead>
<tr>
<th>(K4) 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>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 431</td>
<td>Continued From page 28</td>
<td></td>
<td>The QA Committee will review and make recommendations as needed. The QA Committee consists of the Medical Director, Administrator, DON, Director of Therapy, MDS Nurses, Social Worker, Activities Director, Food Services Supervisor and other Department Heads. The Administrator and DON will monitor for compliance. Completion Date: 8-22-11</td>
<td></td>
</tr>
<tr>
<td>F 441</td>
<td>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SS=K</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 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
<table>
<thead>
<tr>
<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>F441</td>
<td>The facility will ensure that infection control practices are maintained by cleaning the accu-check machine before and after each use to prevent the possible cross contamination between residents by taking the accu-check machine from resident to resident.</td>
</tr>
</tbody>
</table>

The facility DON immediately re-in-serviced licensed nurses and witnessed return demonstrations. The 11/7 shift was re-in-serviced by the DON 7/25/11 upon arrival to the building prior to taking report or using the glucometer. Nurses not on duty were re-in-serviced prior to using the glucometers by the DON, Nurse Supervisor or Staff Development Nurse.

New hires will be in-serviced as part of orientation by the Staff Development Nurse prior to being allowed to perform glucometer checks.

Weekly monitoring will be conducted for three months. Monthly monitoring will continue for six months. Random audits will be done thereafter.

The DON or her designee will be responsible.

---

(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:

A. Based on review of the "Centers for Disease Control and Prevention" (CDC) guidelines, policy review, medical record review, observation and interview, it was determined 2 of 5 (Nurse #1 and 4) nurses failed to maintain infection control practices in 2 of 3 locations (200 and 300 Hall) in the facility to prevent the possible cross-contamination between residents by taking the accu-check machine from resident to resident without cleaning the accu-check machine before and after each use. The facility used the same accu-check machine for 3 (Resident #13, Random Resident (RR) #1 and 2) residents on the 200 Hall, and 1 (Resident #11) resident on the 300 hall. Observations on the upper 300 Hall on 7/25/11 at 4:40 PM, revealed Nurse #4 performed an accu-check on Resident #11, then went to another room on the 300 hall to perform another accu-check. Nurse #4 was stopped by the surveyor at 4:40 PM prior to the accu-check procedure being done. Observation of one of the
**F 441**

Residents that had an accu-check performed had a diagnosis of Chronic Hepatitis which placed the remaining residents receiving accu-checks in Immediate Jeopardy (IJ) when the accu-check instrument was not cleaned between residents. In the Social Services office on 7/25/11 at 4:15 PM, the Administrator and Director of Nursing (DON) were informed of the findings that placed the residents receiving accu-checks in Immediate Jeopardy with an effective date of 7/25/11. The facility put corrective actions in place on 7/25/11 and 7/26/11 to remove the IJ, resulting in a decrease in the scope and severity for F 441 to an E.

The findings included:

1. Review of the "Centers for Disease Control [CDC] and Prevention" guidelines documented, "...Infection Prevention during Blood Glucose Monitoring and Insulin Meters...Whenever possible, blood glucose meters should be assigned to an individual person and not be shared. If blood glucose meters must be shared, the device should be cleaned and disinfected after every use..."

2. Review of the facility's "CLEANING AND DISINFECTING DIAGNOSTIC EQUIPMENT" policy documented, "...1. After completing the test, wipe the blood glucose meter with a bleach based wipe...4. Wipe machine with the bleach based wipe until it is completely wet...5. Allow to remain wet for 1 minute at room temperature...6. Wipe dry or allow to air dry...8. Repeat this procedure between each resident usage and at the end of each shift..."

**Completion Date: 7/25/11**
<table>
<thead>
<tr>
<th>F 441</th>
<th>Continued From page 31</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Medical record review for Resident #11 documented an admission date of 11/26/10 and a readmission date of 4/29/11 with diagnoses of Muscle Weakness, Late Effect Cerebrovascular Disease, Anemia, Hypertension, Diabetes, Congestive Heart Failure, Osteoarthritis, Coronary Atherosclerosis, and Hepatic Cirrhosis. A physician's order dated 7/11/11 documented, &quot;...ACCUCHECK BEFORE MEALS AND BEDTIME...&quot;</td>
<td></td>
</tr>
</tbody>
</table>

Observations during medication administration on the upper 300 Hall on 7/25/11 at 4:30 PM, revealed Nurse #4 entered Resident #11's room and obtained an accu-check on Resident #11. Nurse #4 obtained supplies for another accu-check and started to enter another room on the 300 hall to perform an accu-check on another resident without cleaning the accu-check machine. Nurse #4 was stopped at that time by the surveyor, prior to performing the procedure.

4. Medical record review for Resident #13 documented an admission date of 8/17/10 with diagnoses of Diabetes Mellitus (DM), Muscle Weakness, Dysrhythmic Disorder, Chronic Hepatitis, Depression and Anxiety. A physician's order dated 7/8/11 documented, "...ACCUCHECK BEFORE MEALS AND BEDTIME..." This resident had a diagnosis of Chronic Hepatitis and was receiving accu-checks.

Observations during medication administration in Resident #13's room on 7/25/11 at 3:45 PM, revealed Nurse #1 entered the room and obtained an accu-check on Resident #13. Nurse #1 entered Random Resident (RR) #1's room at 3:55 PM and obtained an accu-check on RR #1.
DOVE HEALTH & REHAB OF COLLIERVILLE, LLC  

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X4) 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-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 441</td>
<td>Nurse #1 entered RR #2's room at 4:00 PM and obtained an accu-check on RR#2. Nurse #1 did not clean the accu-check machine at any time during this observation.</td>
<td>F 441</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Medical record review for Resident #15 documented an admission date of 6/29/10 with a readmission date of 5/18/11 with diagnoses of Chronic Hepatitis, Chronic Respiratory Failure, Continuous Mechanical Ventilator, Tracheostomy Status, Gastrostomy Status, Diabetes, Chronic Obstructive Pulmonary Disease, and Congestive Heart Failure. This resident had a diagnosis of Chronic Hepatitis and was receiving accu-checks.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. There were 28 residents in the facility that received accu-checks. Each resident did not have their own accu-check machine. Each resident that had orders for a finger stick blood glucose had a finger stick with a lancet to obtain a blood glucose reading. The test strip is placed in the accu-check machine. The resident will then have a finger stick and a blood droplet will be dropped onto the strip. The blood could drop on the accu-check machine. When squeezing the finger for the drop of blood the nurse could get non-visible blood on the glove and carry it to the instrument. Nurse #1 and 4 did not clean the accu-check machines prior to use nor between each resident use, placing all residents that have accu-checks performed at risk of a blood borne illness.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. During an interview on the lower 200 Hall on 7/25/11 at 5:50 PM, when asked if Nurse #1 had been instructed on procedure for cleaning the accu-check machine, Nurse #1 stated, &quot;...between residents and at the end of the shift...&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
F 441 Continued From page 33
and let it air dry. I was trained during orientation
and again tonight."

8. During an interview on the upper 300 hall at
7/25/11 at 5:55
PM, Nurse #4 stated, "I thought it was a general
thing to clean it before the shift and after. I didn't
know it had to be cleaned between residents. I
have been inserviced tonight."

9. During an interview in the Social Services
office on 7/25/11 at 6:00 PM, the DON stated, "The
previous DON said she inserviced the nurses
for cleaning the glucometer (accu-check
machine), but as for me I have not inserviced
them since I've been here." When asked if Nurse
#4 and Nurse #1 had received any training on
accu-checks the DON stated, "...I'm unaware of
any. They are both new nurses..." When asked
if pharmacy had inserviced any nurses on
accu-checks the DON stated, "...The pharmacist
is on vacation and she is unaware, but she had
observed a medication pass..." When the DON
was asked what is used to clean the accu-check
machine, the DON said that Dispatch wipes
(bleach wipes) are used. The DON stated, "It
should be cleaned before and after each
resident."

10. During an interview in the Social Services
office on 7/25/11 at 6:25 PM, the DON said that
all of the 3 to 11 nurses had been inserviced, and
that she (DON) would be back at 11:00 PM to
inservice the 11 to 7 shift.

11. During an interview on the 100 Hall on
7/25/11 at 6:33 PM, Nurse #2 stated she had
received training at 6:00 PM on 7/25/11.
<table>
<thead>
<tr>
<th>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-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 441</td>
<td>Continued From page 34</td>
<td>F 441</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. During an interview on the 300 Hall on 7/25/11 at 6:40 PM, Nurse #4 was asked if she had an inservice on cleaning the accu-check machine. Nurse #4 stated, "A little while ago, about 1 hour ago". Nurse #4 stated she was told to clean before the machine is used and after.

13. During an interview with the Medical Director in the conference room on 7/25/11 at 7:00 PM, it was explained that there was an accu-check performed on a resident that evening that had Chronic Hepatitis and that the accu-check machine had not been cleaned between residents. When asked what her expectations are regarding accu-checks, the Medical Director stated, "I expect them to go by facility protocol and manufacturer's instructions."

B. Based on review of the "Geriatric Medication Handbook", policy review, observation, and interview, it was determined the facility failed to ensure 2 of 11 (Nurse #3 and 4) nurses failed to prevent the potential spread of infection by not washing hands during medication administration observations.

The findings included:


2. Review of the facility's "HANDWASHING" policy documented, "...Handwashing is generally..."
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LTC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F441</td>
<td>Continued From page 35 considered the most important single procedure for preventing nosocomial infections...Hands should be washed before and after resident care...personal care and after contact with a resident's mucous membranes and body fluids or excretions...Hands should be washed before and after performing invasive procedures...&quot;</td>
</tr>
</tbody>
</table>

3. Observations in Random Resident (RR) #3's room on 7/25/11 at 4:25 PM, revealed Nurse #3 applied gloves and performed an accu-check on the resident. Nurse #3 did not wash her hands prior to applying gloves or performing the accu-check.

Observations in RR #4's room on 7/25/11 at 4:40 PM, revealed Nurse #4 applied gloves and obtained an accu-check on the resident. Nurse #4 did not wash her hands prior to applying gloves and obtaining accu-check or after removing gloves.

Observations in Resident #3's room on 7/25/11 at 5:15 PM, revealed Nurse #3 applied gloves, administered 1 eyedrop to Resident #3's right eye, then to Resident #3's left eye. Nurse #3 did not wash her hands prior to applying the gloves and administering the eyedrops, and did not change her gloves or wash her hands in between each eyedrop administration.

4. During an interview in the Social Services office on 7/27/11 at 4:00 PM, the DON was asked what her expectation was for handwashing during medication administration. The DON stated, "...I want them [nurses] to wash their hands before and after resident contact...between accu-checks...when applying eyedrops...and in
<table>
<thead>
<tr>
<th>(X4) ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 441</td>
<td>Continued From page 36 between eyedrops...&quot;</td>
<td>F 441</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**RECEIVED:**

AUG 19 2011