F 000

INITIAL COMMENTS

Complaint investigation number #30416, #31314, #31491, #31880, #32207, #32390, #32457, and #32474 were completed on September 11-17, 2013, at Kindred Nursing and Rehabilitation - Smith County. No deficiencies were cited related to complaint investigation #30416, #31314, #32207, #32390, #32457, and #32474. Deficiencies were cited related to complaint investigation #31491 and #31880, under 42 CFR Part 483, Requirements for Long Term Care Facilities.

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483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES

The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, review of facility policy, review of facility documentation, observation, and interview, the facility failed to allow choices for one resident (#4) of fourteen residents reviewed.

The findings included:

Resident #4 was admitted to the facility on April 18, 2013, and readmitted on June 8, 2013, with diagnoses including Multiple Sclerosis, Chronic Obstructive Pulmonary Disease, Morbid Obesity,

LABORATORY DIRECTORS OR PROVIDER/ SUPPLIER REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the facility may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 80 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
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Continued From page 1

Recurrence of Depressive Psychosis, Anxiety, Chronic Liver Disease, and Diabetes Mellitus.

Medical record review of an annual Minimum Data Set (MDS) dated August 26, 2013, revealed the resident was cognitively intact and required extensive assistance with all Activities of Daily Living (ADL's).

Medical record review of the Care Plan dated September 4, 2013, revealed "...altered in Mood/behaviors, monitor for behaviors, demanding/crying behaviors, administer Ativan (anxiety) as ordered, dependent on staff for all ADL's, required four staff for transfers and a lift..."

Medical record review of a Nurse's Note dated June 2, 2013, at 8:30 p.m., revealed "...resident up to smoke and came back in at 9:00 p.m., from smoking. Resident on the call light constantly wanting to be put back to bed. Explained firmly that (resident) could not be put back to bed immediately..."

Medical record review of a Nurse's Note dated June 2, 2013, at 9:30 p.m., revealed "...Remains on call light informed resident...was abusing the call light..."

Medical record review of a Nurse's Note dated June 2, 2013, at 9:45 p.m., revealed "...informed resident that nursing assistants were on the hall and were starting to make rounds and would put (resident) in bed..."

Medical record review of a Nurse's Note dated June 2, 2013, at 9:50 p.m., revealed "...on light requesting to go to bed..."
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 242</td>
<td>Continued From page 2</td>
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<tr>
<td></td>
<td>Medical record review of a Nurse's Note dated June 2, 2013, at 10:05 p.m., revealed &quot;...on light wanting to go to bed...&quot;</td>
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<tr>
<td></td>
<td>Medical record review of a Nurse's Note dated June 2, 2013, at 10:30 p.m., revealed &quot;...on light...&quot;</td>
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<tr>
<td></td>
<td>Medical record review of a Nurse's Note dated June 2, 2013, at 10:45 p.m., revealed &quot;...very argumentative about care and (resident's) needs not being met...have to leave room as resident wants to argue constantly...&quot;</td>
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<tr>
<td></td>
<td>Medical record review of a Nurse's Note dated June 2, 2013, at 10:55 p.m., revealed &quot;...Yelling loudly help me...remains argumentative...&quot;</td>
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<td></td>
<td>Medical record review of a Nurse's Note dated June 2, 2013, at 11:15 p.m., revealed &quot;...when light answered...feared falling asleep...informed...fell asleep we would awaken...put...to bed...&quot;</td>
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<td></td>
<td>Medical record review of a Nurse's Note dated June 2, 2013, at 11:20 p.m., revealed &quot;...putting resident to bed...demanding and rude to staff...repositioned without success...&quot;</td>
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<td></td>
<td>Medical record review of a Nurse's Note dated June 2, 2013, at 11:20 p.m., revealed &quot;...Call placed to MD (Medical Director) updated on agitation and argumentative and could not please resident...N.O. (new order) Ativan (anti-anxiety) IM (intramuscular) 1 mg (milligram) now and Q (every) 6 hours PRN (as needed) x (times) 3 days for agitation...&quot;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review of facility policy &quot;Resident Rights&quot; dated</td>
<td></td>
</tr>
</tbody>
</table>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/LICA

IDENTIFICATION NUMBER

445172

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY COMPLETED

C

09/18/2013

NAME OF PROVIDER OR SUPPLIER

KINDRED NURSING AND REHABILITATION SMITH COUNTY

STREET ADDRESS, CITY, STATE, ZIP CODE

112 HEALTH CARE DR

CARTHAGE, TN 37030

summary statement of deficiencies

(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID

PREFIX

TAG

ID

PREFIX

TAG

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCE TO THE APPROPRIATE
DEFICIENCY)

(X5) COMPLETION DATE

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Continued From page 3

April 28, 2009, revealed "...Residents have
autonomy and choice."

Review of facility documentation (hand written
statement) dated June 8, 2013, revealed ". . . after
the resident would not calm down or be reasoned
with after being put in bed medication was
administered but as I was giving (resident) started
yelling I refuse, I refuse."

Observation on September 11, 2013, at 3:00
p.m., revealed the resident in the dining room, in
a reclining chair, attending activities.

Observation and interview with the resident on
September 12, 2013, at 9:30 a.m., in the
resident's room, revealed the resident had
requested to go to bed after the resident smoked
on June 2, 2013, and the supervisor would not
instruct the staff to assist the resident back to
bed. The resident stated after "several hours" it
seemed like, the staff placed the resident in the
bed.

Interview with Licensed Practical Nurse (LPN) #1
on September 12, 2013, at 6:35 a.m., revealed
the LPN worked on June 2, 2013, and the
Supervisor did not request assistance from the
LPN to place the resident in the bed.

Interview with Certified Nurse Assistant (CNA) #1
on September 12, 2013, at 6:40 a.m., revealed
the CNA had assisted three other staff members
to place the resident back to bed on June 2,
2013. The CNA stated unsure how long the
resident had been up. This was the first time the
CNA had been requested to place the resident to
bed. "When the shift changed no report was
given the resident had been out of the bed. The
| F 242 | Continued From page 4 resident was always in the bed when 3rd shift comes on."

Interview with the Director of Nursing (DON) on September 12, 2013, at 12:30 p.m., in the DON’s office, revealed the resident had requested to go to bed for over two hours. Continued interview confirmed the facility had failed to honor the residents request to be assisted to bed.

C/O #31880

F 431 | It is the practice of this Center to store controlled medications in a safe and legal manner.

There were no resident(s) identified as affected by this deficient practice. No resident missed receiving their ordered medication.

Residents who have the potential to be affected by this deficient practice are all residents of the Center who are treated with controlled medication. A complete investigation that included the local Police was conducted. The Center, Nurses Station, Medication Room, Medication Carts were searched. Employee personal items were reviewed. No findings. (03/31/13, 04/01/13)

All controlled medication were reviewed and counted (Medication Carts and Medication Room). No other medications were found to be missing. Pharmacist notified. (03/31/13). Medication replaced.

Licensed Nursing staff in-serviced as to proper procedure for the acceptance and storage of controlled medications. (04/01/13). Reviews were performed by Nursing Management on shift during medication delivery to the Center to ensure compliance. (04/01-02-03-04-05-06-07).

Two Licensed Nurses are required to count and received medication. The controlled...
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

F 431 Continued From page 5
controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on review of facility documents, review of facility policy, and interview, the facility failed to store controlled medications in a safe and legal manner.

The findings included:
Review of a Medication Variance Report Worksheet dated March 31, 2013, revealed "...Missing narcotics 30 tabs Oxycodeone/Acetaminophen (schedule II narcotic) disappeared from nursing desk..."

Review of a Shipping Manifest dated March 30, 2013, revealed Licensed Practical Nurse (LPN) #1 and LPN #2 signed the form indicating they had received thirty Oxycodeone/Acetaminophen 7.5/325 mg (milligram) from the pharmacy courier.

Review of an Electronic Shipping Manifest provided by the pharmacy to the facility on March 31, 2013, revealed "...Oxycodeone/Acetaminophen 7.5-325 ...QTY (quantity) 30...Status accepted...Received by (named Registered Nurse)..."

Medications are then placed in a locked compartment and the manifest signed by both nurses. A copy of the signed document is kept at the Center and the Pharmacy verifies a copy of their signed original to the DON for review.
Licensed Nursing staff in-serviced as to proper procedure for the acceptance and storage of controlled medications in orientation, skills check off and in their annual in-service. Controlled Medications are stored in a separately locked, permanently fixed compartments for storage of controlled drugs on Medication carts and in the medication Room. Medication Acceptance and Storage Monitoring will be monitored by the shift Supervisor, The DON and the Pharmacy. The procedure now requires two licensed nurses to sign for the medication with the original signed document taken back to the Pharmacy. The copy is kept to be given to the DON. The Pharmacy then exchanges a copy of the original to the DON for the next business day to validate the copy. The controlled medication is then locked in the medication cart or the medication room. All controlled medications are counted and signed for at change of shift. The results of Medication Acceptance and Storage Monitoring will be reported Monthly x3 and quarterly thereafter until resolution to the Center PI (QA) Committee.
A monthly Pharmacy Consultant review is conducted and reported in the PI Committee. Any Corrective actions will be monitored through the Center PI (QA) Committee.
F 431 Continued From page 6
Review of facility policy, Controlled Medications, dated April 29, 2013, revealed "...Store medications listed in Schedules II, III, IV, and V under double lock in a locked cabinet or safe designated for that purpose, separate from other medications...."

Interview with the Director of Nursing (DON) in the DON's office, on September 12, 2013, at 7:10 a.m., confirmed the facility had failed to store Schedule II narcotics in a safe and legal manner.

C/O #31491

F 431
The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s).
The Administrator is responsible for overall compliance.