F 308 PROVIDE CARE SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

- Based on medical record review, observation, and interview, the facility failed to follow the physician's orders for one resident (#38) of twenty-four residents reviewed.

The findings included:

- Resident #38 was admitted to the facility on March 18, 2013, with diagnoses including Hypertension, Back Pain, Coronary Artery Disease, and Chronic Obstructive Pulmonary Disease.

- Medical record review of the Physician's Orders dated March 18, 2013, revealed "...Xanax (anxiety)...1 mg (milligram)...1 tab po (by mouth) with meals...Hold for sedation, decreased RR (respiratory rate) or SBP (systolic blood pressure) (less than) 100..."

- Medical record review of the vital signs dated March 18, 2013, at 7:40 a.m., revealed the blood pressure was 98/68.

- Medical record review of the Electronic Clinical

What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

- Xanax 1mg was administered to resident #38 outside blood pressure parameters on 3/18/13

- Patient experienced mild sedation for 24 hours with no significant harm to the resident.

- Counseling was given to the nurse on 3/18/13 who administered the medication outside of parameters.

- How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

- All YCU nurses were informed of the deficiency details by 3/27/12. Education by the DON included following MD orders completely, reviewing orders daily for any changes, reading comments in the Electronic Medication System that may pertain to the medication and that medication parameters must be followed before administering.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patient. (See instructions.) Except for nursing homes, the findings stated above are discardable 90 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 discardable 14 days following the data these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSD IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX 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 309</td>
<td>Continued From page 1</td>
<td>Summary Medication Administration Record dated March 18, 2013, revealed Xanax 1 mg was administered at 8:45 a.m.</td>
<td>F 309</td>
<td></td>
<td>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?</td>
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<td></td>
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<td>Medical record review of a Physician’s Progress Note dated March 19, 2013, revealed &quot;...decrease Xanax (second to) lightheartedness (drowsiness)...&quot;</td>
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<td></td>
<td>A medication administration MAR review has been initiated; this will identify medications with parameters and the appropriate administration on a daily basis. The charge nurse of the shift will review 50% of the census of that shift. The DON will monitor this for a minimum of 90 days to assure compliance.</td>
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<td>Medical record review of a Physician’s Order dated March 19, 2013, revealed &quot;...Xanax 0.5 mg, 1 tab po with meals...hold for sedation, decreased RR or SBP (less than) 100...&quot;</td>
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<td></td>
<td>How will the corrective action be monitored to ensure the deficient practice does not recur?</td>
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<td>Observation on March 18, 2013, at 2:00 p.m., 3:00 p.m. and 4:00 p.m., revealed the resident lying on the bed with eyes closed.</td>
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<td></td>
<td>The DON will do progressive counseling for any nurse who does not follow the correct practice for administering medications. The DON will continue to do random audits of the Medication Administration Records for an additional 3 months to assure compliance is maintained.</td>
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<tr>
<td></td>
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<td>Observation on March 19, 2013, at 7:45 a.m., revealed the resident lying on the bed with eyes closed. Continued observation revealed the resident would awaken when name was called, but then closed eyes again.</td>
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<td>Observation on March 19, 2013, at 9:00 a.m. and 12:30 p.m., revealed the resident lying on the bed with eyes closed.</td>
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<td>Interview on March 19, 2013, at 3:30 p.m., with the Director of Nursing (DON), in the DON’s office, confirmed the Physician’s Orders were not followed.</td>
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<tr>
<td>F 314</td>
<td></td>
<td>433.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</td>
<td>F 314</td>
<td></td>
<td>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores</td>
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</tbody>
</table>
| F 314 | Continued from page 2. Does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:

- Based on medical record review, observation, and interview, the facility failed to follow physician's orders for wound care for three residents (#87, #97, #98) of twenty-four residents reviewed.

The findings included:

- Resident #87 was admitted to the facility on March 16, 2013, with diagnoses including Pneumonia, Deep Vein Thrombosis, Anticoagulant Use, Stage 2 Pressure Ulcer, and Congestive Heart Failure.

- Medical record review of the electronic Nursing Notes dated March 16-19, 2013, revealed the resident received treatment for a Stage 2 Pressure Ulcer of the left gluteal (buttock) area with Aloe Vesta (a medicated ointment used to treat pressure ulcers). Continued medical record review revealed no corresponding Physicians Orders for pressure ulcer treatment were present.

- Observation of the resident on March 19, 2013, at 3:45 p.m., in the residents room revealed, the resident with a Stage 2 pressure ulcer measuring 1.0 cm (cubic centimeters) x (by) 0.5 cm x 0.0 cm on the right lateral coccyx, and a second

| F 314 | What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

- Resident 87. An order for wound care was not present, and the resident was receiving treatment. An order for wound care consult was obtained at 16:11 on 3/19/13 and physician orders were obtained and initiated on 3/19/13.

- Residents 97 and 98. A wound care consult was done and orders initiated. Barrier ointments were not documented as ordered. A skin assessment was completed on 3/19/13. The wound care had not been done as ordered but the wounds on both residents were improved.

- How will the facility identify other residents having the potential to be affected by the same deficient practice and what action will be taken?

All TCU nurses were informed of the deficiency and counseled on following physician's orders and the appropriate documentation of treatments by 3/27/13. Education by the DON.
**F 314** Continued From page 3

Stage 2 pressure ulcer measuring 1.0 cm x .10 cm x .00 cm on the left lateral coccyx.

Interview with the Director of Nursing on March 18, 2013, at 4:30 p.m. in the conference room, confirmed the facility had failed to obtain Physician's Orders for treatment of the wound.

Resident #97 was admitted to the facility on March 11, 2013, with diagnoses including Respiratory Failure, Congestive Heart Failure, and Chronic Kidney Disease Stage IV.

Review of the Braden Scale (10 or above high risk) dated March 11, 2013, revealed the resident was at moderate risk for the development of pressure ulcers.

Medical record review of a Clinical Note dated March 11, 2013, revealed the resident had a Stage II pressure ulcer on the sacral area present on admission and wound care would be consulted.

Medical record review of a Wound Care Consult dated March 12, 2013, revealed "...Right medical glit (toilet) with stage II pressure ulcer 2 (cm) x 1.9 (cm) x 0.2 (cm) periwound denuded scant amount of drainage noted...recommends Triad ointment (protective ointment) every 8 hours and PRN (as needed)..."

Medical record review of a Physician's Order dated March 12, 2013, revealed the pressure ulcer to the buttock was to be cleansed and Triad was to be applied every eight hours.

Medical record review of the electronic Treatment
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LTD IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 314</td>
<td>Continued From page 4</td>
<td>Order Notes revealed the pressure ulcer was treated with the Triad twice daily from March 12-18, 2013. Observation on March 18, 2013, at 4:10 p.m., with Licensed Practical Nurse (LPN) #1 revealed the resident lying on the bed. Continued observation revealed the resident was positioned on the left side, the incontinence brief was removed revealing a wound on the right buttck. Observation and interview with LPN #1 on March 19, 2013, at 4:10 p.m., revealed the wound was described by LPN #1 as a Stage II pressure ulcer measuring 0.3 cm x 0.5 cm with less than 0.2 cm in depth. Interview on March 18, 2013, at 3:35 p.m., with Registered Nurse (RN) #1, in the conference room, revealed the resident received wound care twice a day from March 12-18, 2013, and confirmed the resident did not receive the Triad ointment to the pressure ulcer every eight hours as ordered by the physician. Resident #98 was admitted to the facility on March 14, 2013, with diagnoses including Hypertension, Hypothyroid, Diabetes, Coronary Artery Disease, and Pressure Ulcer. Medical record review of the Braden Scale dated March 14, 2013, revealed a score of 11. Medical record review of a Progress Note dated March 15, 2013, revealed &quot;...Wound Care Consult-Right medial glut (buttock) stage II pressure ulcer 1.2 (cm) x 1 (cm) x 0.2 (cm) with pink moist wound bed. Coccyx with three stage II pressure areas measuring 0.2 cm to 1 cm in...&quot;</td>
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</tbody>
</table>
F 314: Continued from page 5

diameter 0.1 cm in depth. Scant amount of serosanguineous drainage. Patient very resistant to repositioning...

Medical record review of a Physician's Order dated March 15, 2013, revealed "...Wound Care; Stage II pressure ulcer right medial buttck/ococyx. Cleanse with soft wipes...pat dry, apply Triad ointment to affected area every 12 hours..."

Medical record review of a Progress Note dated March 19, 2013, revealed "...wound care consult-right medial glut stage II pressure ulcer 1.2 (cm) x 1 (cm) x 0.2 (cm) wound bed pink moist-periwound intact--ococyx stage II pressure ulcer 1 (cm) x 0.4 (cm) x 0.1 (cm) with 100% granulation...patient incontinent which is contributing to skin breakdown--recommend no diapers...keep off affected area as much as possible...recommend versa care bed."

Medical record review of the Progress Note dated March 20, 2013, revealed "...Wound Care follow up--Right medial (buttock), coccyx...stage II pressure ulcers remain unchanged from 3/19/13 visit-Patient has versa bed in place to assist with preventing shearing and friction..."

Medical record review of the Electronic Treatment Order Notes revealed treatment to the pressure ulcers documented one time a day on March 15, 16, 17 and 18, 2013.

Observation and interview with Registered Nurse #3, on March 20, 2013, at 9:00 a.m., revealed the resident had a Stage II pressure ulcer to the right buttck and to the coccyx.
<table>
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<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LTC IDENTIFYING INFORMATION)</th>
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<tbody>
<tr>
<td>F 314</td>
<td>Continued From page 6</td>
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<tr>
<td>F 371</td>
<td>483.35(i) FOOD PROCEDE, STORE/PREPARE SERVE - SANITARY</td>
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</tbody>
</table>

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

This REQUIREMENT is not met as evidenced by:
Based on observation, review of facility policy, and interview, the facility failed to provide sanitary storage of food and equipment.

The findings included:
Observation of the dietary department on March 18, 2013, from 10:30 a.m. until 11:30 a.m., revealed the following opened, undated, and available for use:
- Buttermilk biscuit, 5 pound box open
- Cornbread mix, 5 pound box under the preparation table
- (2) 18 ounce peanut butter jars on the preparation table
- 1 gal Italian free dressing in the reach in cooler

What corrective action will be accomplished for the residents found to have been affected by the deficient practice?
All items identified in Tag 371 were discarded immediately. No harm occurred to any patients.

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?
The staff members that were delinquent in properly labeling and storing food on 3/18/13 were immediately counseled by the dietary director. Education with the reminder of the nutritional services staff was done by the dietary supervisor and was completed by 3/18/15.
**F 371** Continued From page 7

16 oz. whipped topping in dispensing bag in the reach in cooler

(4) 19.25 oz bottles of Vanilla, Rasperry, and Caramel plate decorating syrups in the reach in cooler.

Banana extract 16 oz. In the reach in cooler

Orange extract 16 oz. In the reach in cooler

1 gallon liquid butter under the preparation table

Further inspection revealed a box of forty-eight four ounce hamburger patties stored over four containers of cooked macaroni and cheese in the walk-in cooler.

Review of facility policy, Food and Supply Storage Procedures, last revised on January 2012, revealed, "...cover, label, and date unused portions and open packages...Thaw meats in the cooler. Raw ingredients must be stored below cooked products..."

Interview with the Dietary Supervisor on March 18, 2013, at 11:35 a.m., in the dietary department, confirmed the open packages of food were not dated when opened and confirmed the raw hamburger patties were stored above the cooked macaroni and cheese in the walk-in cooler.

**F 401**

**INFECTION CONTROL, PREVENT SPREAD, LINENS**

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LTC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLIANCE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 441</td>
<td>Continued From page 8</td>
<td>F 441</td>
<td>What corrective action has been accomplished for those residents found to have been affected by the deficient practice. The isolation breach was reviewed with nurse #4 on 3/20/13. Patient had a history of C-Diff and MRSA. Antibiotic therapy was completed on 3/15/13. Post antibiotic therapy patient was asymptomatic and no adverse outcome was noted for resident #82.</td>
<td>3/20/13, 3/15/13</td>
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<td>(1) Investigates, controls, and prevents infections in the facility;</td>
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<td>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</td>
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<td>(3) Maintains a record of incidents and corrective actions related to infections.</td>
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<td>(b) Preventing Spread of Infection</td>
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<td></td>
<td>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</td>
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<td>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</td>
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<td>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</td>
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<td></td>
<td>(c) Linens</td>
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<td>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</td>
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<td></td>
<td><strong>This REQUIREMENT</strong> is not met as evidenced by:</td>
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<td>Based on observation, and interview, the facility failed to follow infection control standards for contact isolation for one resident (#82) of twenty-four residents reviewed.</td>
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<td>The findings included:</td>
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</tbody>
</table>
### Statement of Deficiencies and Plan of Correction

#### (X1) Provider/Supplier/Client Identification Number
- 445365

#### (X2) Multiple Construction
- A. Building: ___________
- B. Wing: ___________

#### (X3) Date Survey Completed
- 03/20/2013

#### Name of Provider or Supplier
- INDIAN PATH MEDICAL CENTER TRANSITIONAL CARE

#### Street Address, City, State, Zip Code
- 2200 BROOKSIDE DRIVE
- KINGSPORT, TN 37660

#### (X4) ID Prefix
- TAG

<table>
<thead>
<tr>
<th>ID Prefix TAG</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded By Full Regulatory Or LSO 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 9 Observation on March 19, 2013, at 2:00 p.m., in the hallway outside the resident's room, during the medication pass, the resident was in contact isolation for Clostridium Difficile (a contagious gastrointestinal illness spread by contact) and for MRSA (Methicillin Resistant Staphylococcus Aureus, a drug resistant contagious bacteria spread by airborne droplets or direct contact). The resident was wearing contaminated PPE and isolation gown. The resident was observed exiting the medication cart in the hallway, returned to the resident room, scanned the resident's bracelet, and returned the bar code scanner to the medication cart. Continued observation revealed RN #4 cleaned the top surface of the cart and barcode scanner with sanitary wipes while wearing contaminated PPE outside the resident's room. Continued observation revealed RN #4 held a clipboard with the contaminated left hand glove, as RN #4 cleaned the cart and barcode scanner with the right hand. Continued observation revealed RN #4 replaced the clipboard on top of the cleaned medication cart with the contaminated left gloved hand. Interview with RN #4 on March 19, 2013, at 2:06 p.m. in the hallway outside the resident's room, confirmed the RN #4 had failed to follow the facility's contact isolation protocols.</td>
<td>F 441</td>
<td>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Nurse #4 received re-education of the current isolation policy and procedure and received counseling on 3/20/13. By 4/5/2013, the remainder of the TCU staff received In-services by the DON and the infection prevention practitioner on isolation policies and procedures. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The DON and/or shift leaders will make daily observations of staff when donning/doffing PPE and compliance of isolation policy and procedure. Laminated signs were made on 4/3/13 and added to the isolation equipment on patients door that show the proper way to remove protective isolation PPE. Signs also posted in the medication room. How will the corrective actions be monitored to ensure the deficient practice will not recur? Unannounced observations upon rounding will be performed by the infection prevention practitioner or designee weekly to observe infection control practices of staff and report noncompliance to the DON. The results will be reviewed monthly to determine if this was a deficient practice or an isolated event.</td>
<td>2/20/13 4/5/13</td>
</tr>
<tr>
<td>F 514</td>
<td>483.75(1)(1) RES RECORDS COMPLETE/ACCURATE/ACCESSIBLE</td>
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**Note:** The provided document contains a detailed narrative of deficiencies observed and the provider's plan of correction, with specific dates and actions outlined for addressing the identified issues. The information is designed to ensure compliance with regulatory and infection control standards.
F 514 Continued From page 10

The facility must maintain clinical records on each resident in accordance with accepted professional 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, observation, and interview, the facility failed to ensure an accurate medical record for one resident (#68) of twenty-four residents reviewed.

The findings included:

Resident #68 was admitted to the facility on March 16, 2013, with diagnoses including Hypertension, Back Pain, Coronary Artery Disease, and Chronic Obstructive Pulmonary Disease.

Medical record review of the Physician's Orders dated March 16, 2013, revealed "...Xanax (anxiety)...1 mg (milligram)...1 tab po (by mouth) with meals...Hold for sedation, decreased RR (respiratory rate) or SBP (systolic blood pressure) (less than) 100..."

Medical record review of the vital signs revealed
Continued From page 11
the blood pressure was 92/60 at 8:00 a.m. on March 19, 2013.

Medical record review of the Medication Administration Record dated March 19, 2013, revealed the Xanax 1 mg was initiated as administered at 8:22 a.m.

Interview on March 19, 2013, at 3:00 p.m., with Licensed Practical Nurse (LPN) #2, in the nursing station, confirmed LPN #2 obtained the blood pressure prior to administering the Xanax but did not document the results of the blood pressure of 102/69.

What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur. A medication administration MAR review form has been initiated; this will identify medications with parameters and the appropriate administration on a daily basis. The charge nurse of the shift will review 50% of the census of that shift. The DON will monitor this for a minimum of 90 days to ensure compliance.

How will the corrective action be monitored to ensure the deficient practice does not recur? The DON will do progressive counseling for any nurse who does not follow the correct practice for administering medications.

The DON will continue to do random audits of the Medication Administration Records for an additional 3 months to assure compliance is maintained.