<table>
<thead>
<tr>
<th>F 176</th>
<th>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</th>
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An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review and interview, it was determined the facility failed to obtain a physician’s order for a resident to self-administer medications for 1 of 19 (Resident #8) sampled residents.

The findings included:

- Review of the facility’s "MEDICATION ADMINISTRATION: Guidelines for Self Administration and Securing Medications" policy documented, "...Self-administration of medications by patients in nursing homes requires a physician’s order. The physician’s order must specify the medicines that are to be self-administered..."

Medical record review for Resident #8 documented an admission date of 4/19/11 with diagnoses of Malignant Neoplasm of Bronchus and Lung, Lymphosarcoma, Pressure Ulcer, Hyperplasia of Prostate and Gastricostomy.

Nursing notes for Resident #8 documented, 
- "4-20-11 2000 [8:00 PM]: Pt [patient] demonstrated ability to give his own meds [medications] through peg [Percutaneous Endoscopic Gastrostomy] tube... 4-23-11 1545 [3:45 PM]: Pt gives self his medications..." There

Resident #8 had order placed from physician on 4-29-11 to self administer meds.

All current resident were reviewed and no other residents were found to be self-administering medications. This was completed on 4-29-11.

All residents will be monitored through the admission process and PCP team to identify any residents able to self administer meds. Residents identified will be reviewed for compliance with orders, teaching and PCP. This will be monitored monthly by the attentions nurse and unit managers.

Results will be reported through the QA process monthly X2 and ongoing as determined by the QA committee.

The Director of Nurses will ensure inservices and QA studies are completed as outlined, and all licensed nurses will be inserviced on center medication self administration policy by 5-31-11.
F 176  Continued From page 1
was no documentation of a physician's order allowing Resident #6 to self-administer his medications.

During an interview in Resident #8's room on 4/26/11 at 4:15 PM, Resident #8 was asked how he takes his medications. Resident #8 stated, "sometimes by mouth and sometimes through the tube [PEG Tube]... sometimes the nurse gives them [medications] and sometimes I do..."

During an interview in the 200 hall on 4/27/11 at 10:30 AM, Nurse #2 was asked if Resident #8 administered his own medications via the PEG Tube. Nurse #2 stated, "...Yes... I crush them [medications] up and he does it [administrates the medication]..."

During an interview in the 200 hall on 4/27/11 at 1:58 PM, Nurse #2 was asked if Resident #6 had a physician's order for self-administration of medications. Nurse #2 stated, "...I would assume so..."

Resident #6 had restraint assessed on 5-3-11 with an attempt to reduce the restraint.

F 221  All other residents with restraints will be reviewed and assessed through the use of staff observation, falls risk assessment and careplan review by the unit managers for appropriate use of restraint or restraint alternative. This will be completed by 5-30-11.

Residents will be monitored daily by the unit managers and the Director of Nursing to ensure compliance with
**F 221** Continued From page 2

Restrains.

The findings included:

Review of the facility’s “Use of Restraints” policy documented, “In those cases where assessment and evaluation have indicated that restraint use is appropriate in the treatment of medical symptoms, adequate documentation must be maintained. The following documentation should appear in the medical record to substantiate the need and use of a restraint: [1]. Restraint/Alternatives... vii. Restraint/Alternatives Re-evaluation...”

Medical record review for Resident #6 documented an admission date of 2/4/10 with diagnoses of Parkinson’s, Hypertension, Diabetes Mellitus II, Senile Dementia, Failure to Thrive Orthostatic Hypotension, Syncope, History of Fall and Gastro Esophageal Reflux Disorder (GERD). Review of the nurse’s note dated 3/28/11 documented, “Observed patient throughout the day. Patient continuously releasing self releasing seat belt with alarm sounding and Patient continuously trying to get out of his wheelchair. Patient is confused and unable to redirect.”

Observations in Resident #9’s room on 4/25/11 at 11:52 AM and 4:05 PM and on 4/26/11 at 12:00 PM and 2:35 PM, revealed Resident #8 seated in rock-n-go chair with pelvic restraint in place.

During an interview at the nursing station near the 300 and 400 hall on 4/27/11 at 8:50 AM, Nurse #5 was asked if any other type of restraint was attempted prior to the use of the pelvic restraint. Nurse #5 stated "Nothing tried after self releasing assessing appropriate use of restraint or restraint alternative. Results will be reported through the Quality Assurance process monthly X 2 and then ongoing as determined by the Quality Assurance Committee.

The Director of Nursing will ensure inservices and QA studies are completed as outlined, and all nursing employees will be inserviced on Restraint Policy by 5-31-11.
Continued From page 3
belt, resident fell, son wanted father tied down, did not try any other restraint."

F 314 483.25(c) TREATMENT/SVS TO PREVENT/HEAL PRESSURE SORES

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores 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 policy review, medical record review, observation and interview, it was determined the facility failed to ensure each resident received treatment to promote healing of a pressure ulcer by failing to keep the wound from contamination during a dressing change and by not following the physician’s order for a dressing change for 2 of 4 (Residents #2 and 3) sampled residents with pressure ulcers.

The findings included:
1. Review of the facility’s “Dressing Change Procedure” policy documented, ". . . 11. Wash hands or use hand gel and don gloves. 12. Remove dressing to be changed and place in red bag. 13. Remove gloves and wash hands or use hand gel. Don clean gloves. 14. Cleanse wound with wound cleanser as ordered..."
F 314 Continued From page 4

2. Medical record review for Resident #2 documented an admission date of 5/7/10 with diagnoses of Multiple Sclerosis, Hypertension, Cerebral Vascular Accident with Hemiplegia, Hyperlipidemia, Anemia, Neurogenic Bladder, Coronary Artery Disease and Pressure Ulcer Stage IV. Review of the wound care treatment records documented Resident #2 had healing Stage IV Pressure Ulcers on the coccyx, Left Hip, Left Buttock, and Right Hip.

Observations during a dressing change in Resident #2's room on 4/26/11 at 9:00 AM, Nurse #1 washed her hands with appropriate techniques, cleaned her hands with hand sanitizer, donned gloves, removed the resident's glasses and television remote control and moved the call light to the resident's pillow. Nurse #1 then removed the pillows from behind Resident #2's back. Nurse #1 and Certified Nursing Assistant (CNA) #1 then used the underpad to lift Resident #2 in the bed and position the resident on his right side. Nurse #1 then removed the dressing from the left buttock ulcer and placed the soiled dressing in the red biohazard bag in the trash can beside the bed. Nurse #1 then sprayed the wound with wound cleanser, took a gauze pad and wiped down the wound from the top to the bottom of the wound. Nurse #1 then removed her gloves. Nurse #1 cleaned the wound after removing the dressing and handling the resident's personal equipment without removing her gloves and washing her hands which contaminated the wound. After washing her hands and donning gloves Nurse #1 removed the soiled dressing from the left hip ulcer, discarded the dressing in the red biohazard bag in the trash can, sprayed the wound with wound cleanser, wiped the wound
F 314. Continued From page 5

from top to bottom with a gauze pad, and then removed her gloves and washed her hands after removing the soiled dressing contaminated the wound. Nurse #1 then removed the dressing from the left coccyx ulcer, discarded the dressing in the red biohazard bag in the trash can, sprayed the wound with wound cleanser, wiped the wound from top to bottom with a gauze pad, and then removed her gloves and cleaned her hands with sanitizer. The failure to remove her gloves and wash her hands after removing the soiled dressing contaminated the wound. After repositioning Resident #2 on his left side Nurse #1 removed the dressing from the right hip ulcer, handed the dressing to CNA #1 to discard in the red biohazard bag in the trash can, sprayed the wound with wound cleanser, wiped the wound from top to bottom with a gauze pad, and then removed her gloves and cleaned her hands with sanitizer. The failure to remove her gloves and wash her hands after removing the soiled dressing contaminated the wound.

During an interview at the 100-200 Nurses Station on 4/27/11 at 9:33 AM, in a discussion with Nurse #1 regarding changing gloves after handling resident's personal equipment and performing wound care, Nurse #1 stated "You're right. I didn't.

3. Medical record review for Resident #8 documented an admission date of 4/19/11 with diagnoses of Lymphosarcoma, Pressure Ulcer of the Buttocks, Gastrostomy, Stage III Lung Cancer, and Hyponatremia. Review of the physician's order dated 4/20/11 documented "ULCERS TO BUTTOCKS; CLEAN WITH"
F 314 Continued From page 6

WOUND CLEANER AND PAT DRY. APPLY SANTYL TO WOUND BED, SPRAY PERIWOUND TISSUE WITH CAVILON AND COVER WITH MEPILEX BORDER. CHANGE DAILY AND PRN [as needed] ACCIDENTAL REMOVAL OR SOILING."

Observations during a dressing change in Resident #8's room on 4/27/11 at 9:05 AM. Nurse #1 used hand sanitizer, donned gloves, handed Resident #8 a paper cup with soiled tissue in it and a roll of bathroom tissue, removed the soiled dressing from the ulcer on the buttocks, discarded the dressing in the red biohazard bag placed at the head of the bed, sprayed the wound with wound cleanser, wiped the wound from top to bottom with a gauze pad, and then removed her gloves and cleaned her hands with sanitizer. Nurse #1 then donned gloves and with a cotton tipped applicator applied Santyl to the wound, and then applied the Mepilex Border to the wound. Nurse #1 cleaned the wound after removing the dressing and handling the resident's personal equipment without removing her gloves and washing her hands which contaminated the wound. Nurse #1 failed to follow the physician order to spray the periwound with Cavilon. Nurse #1 then removed her gloves, cleansed her hands with hand sanitizer, sprayed the top wound with wound cleanser, wiped top to bottom with a gauze pad, and applied a Mepilex border. Nurse #1 failed to don gloves to perform the wound care and did not follow the physician order to apply Santyl to the wound or spray the periwound with Cavilon.

During an interview at the 100-200 Nurses Station on 4/27/11 at 9:33 AM, Nurse #1 was asked...
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X4) ID PREFIX TAG

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

F 314
Continued From page 7
about not using the Santyl on the top wound and
not using the Cavilon as ordered. Nurse #1
stated, "Going to get a new order to not apply
Santyl to the top wound." Nurse #1 stated, "Did
not spray either wound with Cavilon... Will get that
d/ed (discontinued)."

F 323
483.25(h) FREE OF ACCIDENT
HAZARDS/SUPERVISION/DEVICES

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.

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 a resident at risk for falls had
interventions implemented after each fall to
prevent further falls for 1 of 10 (Resident #17)
sampled residents identified with falls. Resident
#17 was assessed at risk for falls. Resident #17
sustained multiple falls between 3/8/10 and
2/22/11 and the facility failed to implement new
interventions after each fall. Resident #17
sustained a fall on 2/22/11 that resulted in actual
harm when Resident #17 required medical
intervention, hospitalization and surgical
intervention for Left Proximal Ulnar Fracture.

The findings included:
Medical record review for Resident #17

F 314
Resident # 17 had Falls Risk Assessment
Completed with review of Care Plan to
address falls. Current Interventions
reviewed to ensure appropriate
interventions in place.
This will be completed by 5-31-11.

F 323
All residents at risk for falls will have Falls
Risk Assessments completed with review
of current Care Plan to ensure that
interventions are appropriate to minimize a
fall or injury. This will be completed by
unit managers and charge nurses by
5-31-11.

Residents will be monitored daily by the
unit managers and the Director of Nurses
to ensure appropriate interventions are put
in place and current Care Plan updated
with any new incident.
Results will be reported through the
Quality Assurance process monthly X 2
and then ongoing as determined by the
Quality Assurance Committee.
The Director of Nurses will ensure that the
in-services and the Quality Assurance
studies are completed as outlined, and all
nursing employees will be inserviced on
Falls Risk and Interventions by 5-31-11.
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<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 323</td>
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<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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Documented an admission date of 3/3/11 with diagnoses of Diabetes Mellitus, Parkinson's Disease, Dysphagia, Aphasia, Congestive Heart Failure, Bipolar Disorder, Essential Hypertension and Hypothyroidism. Review of the Significant Change in Status Minimum Data Set (MDS) Assessment dated 2/15/11, assessed resident #17 with a summary cognitive score of 99 which indicated resident #17 was unable to complete the interview and had a short term memory problem and had moderately impaired cognitive skills. Review of the Post Falls Nursing Assessments documented the following:

a. 3/6/10, fell in room, no injury, intervention was walking assessment.

b. 3/13/10, fell in room, skin tear to elbow, intervention was toileting program.

c. 3/27/10, fell in room, no injury, no new intervention.

d. 8/25/10, fell in bathroom, no injury, no new intervention.

e. 12/28/10, fell in room, intervention was use of non-skid tread.

f. 1/28/11, fell in room, no injury. Intervention was to remind to use wheelchair (WC) or cane to ambulate and if he can’t locate them to have staff assist.

g. 1/24/11, fell in room, no injury, intervention was repositioning.

h. 2/11/11, fell in room, no injury, intervention was providing visual aids, safe shoes and (8) slippers, seat sensor chair alarm, alarmed black floor mat.

i. 2/12/11, fell in room, no injury, no new intervention.

j. 2/13/11, fell in room, red area to back, Depakote & Zyprexa started. Intervention was restorative walking program. Review of the therapy progress note dated 2/14/11.
F 323 Continued from page 9

documented... "Not appro [appropriate] @ [at] this time..." There were no additional interventions put in place at that time to prevent falls.

K. 2/16/11, fell in corridor, no new intervention.
L. 2/18/11, fell in corridor, no injury, no new intervention.
M. 2/22/11, fell in room, no new intervention.
Intervention for falls on 3/13/10, 3/27/10 and 8/28/10 was toileting. Intervention for falls on 12/28/10, 2/8/11 and 2/15/11 was non-skid shoes or slippers. Intervention for falls on 2/8/11 and 2/12/11 was chair alarm. There were no new interventions put in place for falls on 3/27/10, 8/26/10, 2/12/11, 2/18/11 and 2/22/11.

Review of the care plan for Resident #17 initiated on 6/10/10 through update on 2/28/11 documented Resident #17 at risk for falls. The care plan for falls for Resident #17 documented the following: "6/10/10..." to assist me as needed with safe transfers, be alert to increased confusion or change in my mental status, assist me to toilet as I indicate, place my call light within my reach, place my personal items and water within easy reach, report any falls, accidents, or injuries to the charge nurse and/or physician, make sure my alarms are working and turned on..." 2/14/11..."seat sensor chair alarm, bed against the wall..."

Review of the nurse's notes for Resident #17 documented the following:

a. 2/23/11 at 6:00 PM, "noted with edema to L [left] elbow/forearm and N.O. [new order] received to obtain x-ray of area..."

b. 2/24/11 at 3:30 AM, "MD [medical doctor] informed of x-ray results..."
F 323  Continued From page 10

c. 2/28/11 at 7:00 PM, "...pt [patient] went to appt [appointment] with [named] doctor... ortho [orthopedics]... N.P. [nurse practitioner] informed nurse that pt will be admitted for surgery..."

Review of a physician’s history and physical note dated 2/28/11, documented "...on February 23, the patient fell while attempting to access his wheelchair... he sustained a comminuted fracture of the left olecranon..."

Review of a physician’s discharge summary from [named] hospital dated 3/3/11 documented, "...underwent open reduction internal fixation of the left proximal ulna olecranon for a left proximal ulnar fracture..."

During an interview in the 300 hall nurses station on 4/27/11 at 4:55 PM, the Director of Nursing (DON) was asked what he remembered about Resident #17’s falls. The DON stated, "...one fall was a night fall so no non-slip socks on at night... hard to tell what was happening with a dementia patient..." The DON was asked how the staff recognized that Resident #17 had an injury after the fall on 2/22/11. The DON stated, "...he [Resident #17] had pain in his left elbow with putting his left arm through his shirt sleeve and was sent to the doctor..."

During an interview in the 300 hall nurses station on 4/27/11 at 5:05 PM, Nurse #5 was asked if Resident #17 was able to understand when he was reminded to lock his wheelchair or put on non-slip sock. Nurse #5 stated, "...he’s not able to do that cognitively." Nurse #5 was asked why no new interventions were implemented after Resident #17’s falls. Nurse #5 stated, "...he will
### F 323

**Push mats away and unplug alarms... we've tried to find interventions he'd allow... urinalysis done on 1/10/11 and showed no growth... tried bathroom door alarm without success... he fell on 2/22/11 at 5:55 AM... the 23rd is when edema was noted and we notified the doctor and got x-rays... several laboratory tests were done during January and February 2011 and all were within normal limits... The facility was unable to provide documentation of new interventions put in place after the falls on 2/16/11 and 2/18/11.**

**Resident #17 sustained falls on 3/5/10, 3/13/10, 3/27/10, 8/26/10, 12/28/10, 1/8/11, 1/24/11, 2/8/11, 2/12/11, 2/13/11, 2/16/11, 2/18/11 and 2/22/11 with no new interventions implemented on 3/27/10, 8/26/10, 2/12/11, 2/16/11, 2/18/11 and 2/22/11. Resident #17 sustained an injury after a fall on 2/22/11 at 5:55 AM, that resulted in actual harm when Resident #17 fractured his left proximal ulna and was not treated until 2/28/11. He required surgical intervention on 3/4/11 and remained in the hospital until 3/9/11.**

**F 441**

**483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS**

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and 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,
Continued From page 12

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
communicable disease or infected skin lesions
from direct contact with residents or their food, if
direct contact will transmit the disease.
(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.

(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:

Based on policy review, review of Centers for
Disease Control (CDC) and prevention
guidelines, medical record review, observation
and interview, it was determined the facility failed
to ensure infection control practices were utilized
to prevent the spread of infection were followed
for isolation precautions for 1 of 4 (Resident #2)
sampled residents with Clostridium Difficile
(C-Diff) and failed to ensure 1 of 5 nurses (Nurse
#3) used handwashing as indicated during
medication administration.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID PROVIDER/SUPPLIER/CJA IDENTIFICATION NUMBER:**

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<th>(X1) PROVIDER/SUPPLIER/CJA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
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<td>04/27/2011</td>
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**NAME OF PROVIDER OR SUPPLIER**

**NHC HEALTHCARE, HENDERSONVILLE**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1370 OLD SHACKLE ISLAND RD
HENDERSONVILLE, TN 37075

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**ID PREFIX TAG**

| F 441 | Continued From page 13 |

The findings included:

1. Review of the facility's "...INFECTION CONTROL AND HOSPITAL EPIDEMIOLOGY..." policy documented, "I. Administrative Controls/Implementation of New Guidelines A. Education Develop a system to ensure that patients, personnel, and visitors are educated about use of precautions and their responsibility for adherence to them... V. Contact Precautions In addition to Standard Precautions use Contact Precautions, or the equivalent, for specified patients known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the patient (hand or skin-to-skin contact that occurs when performing patient care activities that require touching the patient's dry skin) or indirect contact care activities that require (touching) with environmental surfaces or patient care items in the patient's environment..."

Review of the CDC guidelines for the "Prevention and Control of Clostridium difficile (CDAD) in Long Term Care Facilities" provided by the facility, documented, "...Reservoir... Hospitals and long term care facilities appear to be major reservoirs for C. (Clostridia) difficile. The organism can be cultured from residents with or without diarrhea, from the environment of infected residents, to include beds, baths, bedside commodes, wheelchairs, etc. [closets], and from the hands of health care workers caring for these residents. The spores of the organism can survive for weeks and months in the environment... Private room is recommended, especially for residents who are fecally..."
Continued From page 14

incontinent or who cannot practice good handwashing... Isolation Precautions... Contact precautions should be used for CDAD residents with diarrhea. Hands should be washed frequently with soap and water. Since C. difficile is a spore forming bacteria, alcohol-based hand gels and lotions are not effective in reducing the spread of the organism and are not recommended. Gloves should be worn when entering the room... Long term care facilities should have some system in place for alerting healthcare workers and visitors that a resident is on contact precautions, such as labeling the chart or door of the room, without compromising that resident's privacy...

Medical record review for Resident #2 documented an admission date of 12/10/09 with diagnoses of Congestive Heart Failure, History of Bladder Cancer, Hypertension and Anxiety. Review of a physician's order dated 4/25/11 documented, "...Contact Isolation... C. diff..." Review of laboratory (lab) results dated 4/25/11 documented Resident #2 was positive for C. Diff.

Observations in Resident #2's room on 4/25/11 at 11:05 AM, on 4/26/11 at 8:10 AM and on 4/27/11 at 1:30 PM, revealed red barrels in the room but no sign on the door indicating Resident #2 was infectious.

Observations in Resident #2's room on 4/26/11 at 4:40 PM, Nurse #4 entered the room without donning gloves prior to administering the nebulizer treatment to Resident #2 during medication administration.

During an interview in Resident #2's room in
F 441 Continued From page 15
4/26/11 at 4:55 FM, Nurse #4 was asked what are the red barrels for. Nurse #4 stated, "C diff."

2. Review of the facility's handwashing policy documented, "...ii. Standard Precautions Use Standard Precautions or equivalent, for the care of all patients. A. Handwashing ...1. When to wash hands... d. After any contaminated contact, whether or not gloves are worn e. Before donning gloves and soon as feasible after removal of gloves or other personal protective equipment. f. Before and after caring for each patient. g. During medication pass..."

Observations in Random Resident (RR) #1's room on 4/26/11 at 8:50 AM, Nurse #3 touched RR #1's roommate prior to administering insulin injection to RR #1. Nurse #3 did not use hand hygiene before donning gloves to administer insulin to RR #1.

Observations in RR #2's room on 4/26/11 at 10:40 AM, Nurse #3 administered nasal spray to RR #2. Nurse #3 did not perform hand hygiene after administering the nasal spray and after removing gloves. Nurse #3 left the room and returned to the medication cart.