STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

445342

(XX) PROVIDER/SUPPLIER CLIA
IDENTIFICATION NUMBER:

A BUILDING

NAME OF PROVIDER OR SUPPLIER
WESTMORELAND CARE & REHAB CTR

STREET ADDRESS, CITY, STATE, ZIP CODE
1859 NEW HIGHWAY 62
WESTMORELAND, TN 37186

(XX) ID PREFIX TAG
F 315

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

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

ID PREFIX TAG
F 315

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)

Westmoreland Care and Rehabilitation does not believe and does not admit that any deficiencies existed, before, during, or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract, obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its responses, credible allegations of compliance as part of its ongoing efforts to provide quality of care to residents.

3/31/10

F 315

NO CATHETER, PREVENT UTI, RESTORE BLADDER

Immediate Interventions:
The clinical record for resident #1 and #5 was reviewed by the DON and ADON on 3-9-10 and their current plan of care was updated to reflect the current needs of the residents. C.N.A. #1 and C.N.A. #2 were in-serviced on 3-9-10 by the Staff Development Coordinator on the correct procedure to perform Perineal Care. All available C.N.A.'s were also in-serviced by the Staff Development Director on 3-9-10 on the correct procedure to perform perineal care.

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 disclosable 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 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.
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
*CENTERS FOR MEDICARE & MEDICAID SERVICES*

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(K1) PROVIDER/SUPPLIER/ClinIC IDENTIFICATION NUMBER</th>
<th>(K2) MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>445342</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(K3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/10/2010</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

**WESTMORELAND CARE & REHAB CTR**

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

**1559 NEW HIGHWAY E2**

**WESTMORELAND, TN 37185**

<table>
<thead>
<tr>
<th>(K4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LCD 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>(K5) COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 315              | Continued From page 1 of perineum to back of perineum..."  
During an observation of perineal care in room 110 on 3/9/10 at 2:05 PM, CNA #2 covered part of the bedside table with a towel and put washcloths on the covered area. CNA #2 placed the towel on the part of the table with no barrier. After washing Resident #1's perineal area with the washcloths, CNA #2 dried Resident #1 with the towel she had laid on the uncovered part of the table.  
During an interview with the Director of Nursing's (DON) office on 3/9/10 at 2:45 PM, the DON was informed of the above findings and was asked what she expected of the CNA's during perineal care. The DON stated, "...expect to pull the curtain before washing hands... wash from front to back [anus] area,... put a barrier on, [bedside table]..."  
4. Medical record review for Resident #5 documented an admission date of 1/16/06 with diagnoses of Diabetes with Unspecified Complication, Type II, Psychosis, Anemia, Alzheimer's Disease, Depressive Disorder, Congestive Heart Failure, History of Colon Cancer and Neurogenic Bladder.  
Observations of perineal care in room 202 on 3/9/10 at 1:03 PM, CNA #1 washed her hands. | F 315 | Identification of the residents with potential to be affected:  
A review of all current residents that require perineal care will be conducted by the DON and ADON by 3-25-10. All residents that require perineal care will have their current plan of care updated to reflect the current needs of the resident. The Nursing Staff will be made aware of the current residents that require perineal care by the Staff Development Coordinator by 3-31-10.  
**Measures to prevent reoccurrence:**  
An in-service was completed for all C.N.A.s regarding the appropriate provision of perineal care by the Staff Development Coordinator on 3-10-10. A follow-up in-service regarding performance of appropriate perineal care will be conducted for all C.N.A.s by 3-31-10 by the Staff Development Coordinator. The Staff Development Coordinator and ADON will complete observation of the provision of perineal care for 3 residents weekly for 4 weeks to ensure appropriate techniques is being maintained.  
**Monitoring:**  
Findings of the observations will be forwarded to the DON weekly to ensure continued compliance. Results will be reported to the QA committee monthly for 3 months for recommendations and further follow-up as indicated. | |

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>FORM CMS-2587(02-09) Previous Versions Obsolete</td>
<td>Event ID: 03:B11</td>
</tr>
<tr>
<td>Facility ID: TN0207</td>
<td>If continuation sheet Page 2 of 5</td>
</tr>
</tbody>
</table>
F 315  Continued From page 2

and turned off the water with her bare hand
instead of using a paper towel, dried her hands
and put on her gloves. CNA #1 then pulled the
bedside table with the perineal supplies around
the bed pushing back the curtain as she circled
the bed with her gloved hand. CNA #1 then pulled
Resident #5 up in the bed with her gloved hands
holding the pull sheet. CNA #1 did not remove her
gloves or wash her hands prior to perineal care.
CNA #1 proceeded to wash the perineal area
from front to back. CNA #1 dried the perineal
area, by patting the perineal area from the front to
the back then back to the front again. CNA #1
removed her gloves, used hand sanitizer, went
out to the clean linen cart and removed clean
washcloths without washing her hands with soap
and water after the perineal care. CNA #1
returned to the room, washed her hands, put on
her gloves and then washed Resident #5's anal
area from back to front instead of front to back.

F 332  SS-D

483.25(m)(1) FREE OF MEDICATION ERROR
RATES OF 5% OR MORE

The facility must ensure that it is free of
medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced
by:

Based on review of the medication guide for the
long term care nurse, medical record review,
observation and interview, it was determined the
facility failed to ensure 2 of 8 medication nurses
(Nurses #1 and 2) administered medications with
a medication error rate of less than 5 percent (5%)
for Random Residents (RR #1 and 2). A total of 3
medications errors were observed out of 46
opportunities for error, resulting in a medication

F 332
FREE OF MEDICATION ERROR RATES OF 5% OR MORE

Immediate Interventions:
An assessment was completed by the
ADON on 3/9/10 for resident's #1 and #2.
The residents were determined to suffer
no negative effects from the inhaler being
incorrectly administered. The licensed
nursing staff was immediately in-serviced
by the DON upon identification of the
concern, regarding the correct procedure
to administer an inhaler.
<table>
<thead>
<tr>
<th>[X4] ID PRE/TA</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION]</th>
<th>ID PRE/TA</th>
<th>PROVIDER'S PLAN OF CORRECTION [EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY]</th>
<th>[X5] COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 332</td>
<td>Continued From page 3. error rate of 6.52%.</td>
<td>F 332</td>
<td>Identification of the residents with potential to be affected:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The findings included:</td>
<td></td>
<td>A review of all current residents' medical records will be completed by the DON</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Review of the &quot;Medication Guide for the Long-Term Care Nurse&quot;, sixth edition, page 75,</td>
<td></td>
<td>and ADON by 3-31-10 to identify those residents that require inhalers. The</td>
<td></td>
</tr>
<tr>
<td></td>
<td>documented, &quot;Spacing and Proper Sequence of Inhaled Medications... Spacing and proper</td>
<td></td>
<td>resident's that are identified will have their plan of care updated to reflect</td>
<td></td>
</tr>
<tr>
<td></td>
<td>sequence of different inhalers is important for maximal drug effectiveness. If more than one</td>
<td></td>
<td>the current needs of the resident.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>inhaler is used, following the sequence listed below provide the most benefit to the patient...</td>
<td></td>
<td>Measures to prevent reoccurrence:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Bronchodilators/Beta Agonists... 2. Anticholinergic Agents... 3. Miscellaneous Agents... 4.</td>
<td></td>
<td>The licensed nursing staff was in-serviced on proper administration of inhalers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Corticosteroids... Wait one minute between &quot;puffs&quot; for multiple inhalations of the same drug...</td>
<td></td>
<td>on 3-9-10 by the DON. A follow-up in-service will be conducted by the Consultant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wait 1- [to] 2 minutes before administering next drug...</td>
<td></td>
<td>Pharmacist for licensed nursing staff on 3-18-10. Information regarding appropriate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Medical record review for RR #1 documented an admission date of 9/15/05 with diagnoses of</td>
<td></td>
<td>administration of inhalant medications will be placed in the front of each</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pneumonia, Muscle Weakness, Chronic Obstructive Pulmonary Disease and Congestive Heart Failure.</td>
<td></td>
<td>medication administration record. The ADON will complete observation of 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A physician's order signed 2/28/10 documented, &quot;Xopenex inhaler 2 puffs inhal QID [four times a</td>
<td></td>
<td>inhalant medications weekly for 4 weeks to ensure continued compliance.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>day] Resp [respiratory] distress.&quot;</td>
<td></td>
<td>Monitoring:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Observations in RR #1's room on 3/8/10 at 4:43 PM, Nurse #1 administered Xopenex inhaler 2</td>
<td></td>
<td>Findings of the observation of inhalant medication will be forwarded to the DON</td>
<td></td>
</tr>
<tr>
<td></td>
<td>puffs to RR #1. Nurse #1 did not wait one minute between the 2 puffs. This resulted in medication</td>
<td></td>
<td>to ensure compliance. The results will be reported to the QA committee monthly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>error #1.</td>
<td></td>
<td>for 3 months for recommendations and further follow-up as indicated.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Medical record review for RR #2 documented an admission date of 2/5/08 with diagnoses of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acute Gastritis, Muscle Weakness, Hypertension and Dislocation of Hip. Review of the physician's</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>recertification orders dated 2/1/10 through 2/28/10 documented, &quot;COMBIVENT INHALER...</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td>TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES</td>
<td>ID</td>
<td>TAG</td>
</tr>
<tr>
<td>----</td>
<td>-----</td>
<td>-----------------------------------</td>
<td>----</td>
<td>-----</td>
</tr>
<tr>
<td>F 332</td>
<td>Continued From page 4</td>
<td>INHALE 1 PUFF ORALLY TWICE DAILY... ADVAIR... INHALE 1 PUFF ORALLY EVERY 12 HOURS...&quot; Combivent is a bronchodilator and Advair is a corticosteroid. Observations in RR #2's room on 3/9/10 beginning at 8:34:19 AM, Nurse #2 was observed to connect a spacer chamber to the Advair inhaler. Nurse #2 then administered 2 puffs of the Advair inhaler to RR #2. Nurse #2 had RR #2 to rinse her mouth out with water and spit out the water. Nurse #2 administered one puff of Combivent inhaler at 8:35:00 AM. The corticosteroid was administered before the bronchodilator. Administering 2 puffs of Advair resulted in a medication error #2. Not waiting one minute between medications resulted in a medication error #3. During an interview in the 300 hallway on 3/19/10 at 8:37 AM, Nurse #2 stated, &quot;Should wait 2 to 3 minutes, maybe five minutes between puffs, but when she returned from the hospital, they ordered both [inhalers] at 9 AM.&quot;</td>
<td>F 332</td>
<td></td>
</tr>
</tbody>
</table>