STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER CLA
IDENTIFICATION NUMBER:

445461

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. ROOM

(X3) DATE SURVEY COMPLETED

07/21/2011

NAME OF PROVIDER OR SUPPLIER

COVINGTON MANOR INC

STREET ADDRESS, CITY, STATE, ZIP CODE

1902 HWY 61 S
COVINGTON, TN 38019

(X4) ID PREFIX TAG

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

F 309 SS=E

483.25 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:

Intake: TN00027840

Based on medical record review, observation and
interview, it was determined the facility failed to
follow physician's orders for bowel movement
(BM) protocol, heel pads and/or intake and output
for 5 of 24 (Residents #2, 4, 8, 17 and 22)
sampled residents.

The findings included:

1. Medical record review for Resident #2
documented an admission date of 2/8/06 with
diagnoses of insulin Dependent Diabetes
Mellitus, Schizophrenia, Hypertension and Renal
Failure. Review of the current physician's
recertification orders dated 5/20/11 documented,
"...HEEL PADS BILATERAL..." Review of the
physician's standing orders documented,
"...CONSTIPATION: Once Daily: MOM [Milk of
Magnesia] 30cc [cubic centimeters] po [by
mouth]; or Enema PRN [as needed]; or Bisacodyl
10 mg. [milligrams] supr. [suppository] p.r. [per
rectum] PRN or Bisacodyl 5 mg. tab [tablet] po
PRN,..." Review of the nurse aide care sheet for

BORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE:

DATE

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosed 90 days after the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosed 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued participation.
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April 2011 had no BM documented on April 12, 13, 14, 15 and 16, 2011. Review of the April 2011 medication administration record (MAR) had no laxatives documented as being administered as per the facility's BM protocol.

Observations in Resident #2's room on 7/18/11 at 1:30 PM and on 7/19/11 at 2:00 PM and 4:30 PM, revealed Resident #2 sitting in a geriatric chair with no heel pads on his feet as ordered.

Observations in Resident #2's room on 7/19/11 at 9:00 AM, revealed Resident #2 lying in bed with no heel pads in place as ordered.

Observations in Resident #2's room on 7/20/11 at 8:00 AM, revealed Resident #2 sitting in a geriatric chair with no heel pads on his feet as ordered.

During an interview in Resident #2's room on 7/20/11 at 8:00 AM, Nurse #1 confirmed Resident #2 did not have heel pads on his feet.

During an interview at the 100/200 hall nurses' station on 7/20/11 at 10:30 AM, Nurse #1 was asked about the heel pads and 5 days without a BM. Nurse #1 confirmed that Resident #2 should be wearing heel pads bilaterally and that he should have been given a laxative on the third day of no bowel movement.

2. Medical record review for Resident #4 documented an admission date of 12/29/10 with diagnoses of Seizure Disorder, Congestive Heart Failure, Hypertension, and Dementia. Review of a physician's order dated 7/11/11 documented, "...I/O [intake and output] EVERY SHIFT..."

2. The DON, ADON, and Licensed Nurses completed chart audits, Nurse Aide Care Sheets audits and facility patient rounds on 7/22/11 through 7/25/11 to ensure physician orders are being followed for bowel movement protocol, heel pads, and intake and output.

3. The nursing department was re-visited by the DON on 7/22/11 and 8/15/11 regarding following physician's orders concerning the bowel movement protocol, heel pads, and Intake and output.

4. The O.A. Committee, consisting of Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Risk Management Nurse, MDS Coordinators, Staffing Coordinator, Medical Records, Bookkeepers, Food Service Supervisor, Social Worker, Admissions Coordinator, Maintenance Supervisor, Activities Coordinator, Assistant Activities Coordinator, will monitor for compliance through review of physician orders on the chart, Nursing Aide Care Sheets and resident rounds monthly for three months. If compliance is not met, facility nursing staff will be re-inserviced and audits will continue until substantial compliance is met. Different members of the committee will participate depending on the nature of the audit.

Date of completion: 8/15/11
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Review of the July 2011 MAR had only three days (7/9/11, 7/10/11 and 7/17/11) that I&O was completed as ordered. The facility failed to record the I&O every shift as ordered.

During an interview at the 100/200 hall nurses' station on 7/20/11 at 9:30 AM, Nurse #6 confirmed that I&O was not done as ordered.

3. Medical record review for Resident #8 documented an admission date of 7/2/10 with diagnoses of Renal Failure, Dementia, Congestive Heart Failure and Osteoporosis. Review of the July 2011 nurse aide care sheet had no BM documented on July 3, 4, 5, 6, 9, 10, 11, 12 and 13, 2011. Review of the the physician's standing orders documented, "...CONSTITUTION: Once Daily: MOM 30cc po PRN; or Enema PRN; or Bisacodyl 10 mg. sup. p.r. PRN or Bisacodyl 5 mg. tab po PRN..." Review of the July 2011 MAR had no laxatives documented as being administered when Resident #8 failed to have a BM as per the facility's BM protocol.

4. Medical record review for Resident #17 documented an admission date of 1/7/11 with diagnoses of Pulmonary Edema, Congestive Heart Failure and Dementia. Review of the June 2011 nurse aide care sheet had no BM documented on June 1, 2, 3, 4, 5, 6, 7, 11, 12, 13, 14 and 15, 2011. Review of the the physician's standing orders documented, "...CONSTITUTION: Once Daily: MOM 30cc po PRN; or Enema PRN; or Bisacodyl 10 mg. sup. p.r. PRN or Bisacodyl 5 mg. tab po PRN..." Review of the June 2011 MAR had no laxatives documented when Resident #17 failed to have a
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B. WING
C. ROOM

(X3) DATE SURVEY COMPLETED

07/21/2011

NAME OF PROVIDER OR SUPPLIER

COVINGTON MANOR INC

STREET ADDRESS, CITY, STATE, ZIP CODE

1692 HWY 61 S
COVINGTON, TN 38019

(X4) ID PREFIX TAG

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SUMMARY STATEMENT OF DEFICIENCIES
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BM as per the facility’s BM protocol.

During an interview at the 100/200 hall nurses’ station on 7/20/11 at 10:50 AM, Nurse #1 confirmed that a laxative should have been given on the third day of no bowel movement.

5. Medical record review for Resident #22 documented an admission date of 3/7/08 with diagnoses of Cerebrovascular Accident, Hypertension and Congestive Heart Failure. Review of the physician’s standing orders documented, "...CONSTITUTION: Once Daily: MOM 30cc po PRN; or Enema PRN; or Bisacodyl 10 mg. supp. pr. PRN or Bisacodyl 5 mg. tab po PRN..." Review of the January 2011 nurse aide care sheet had no BM documented on January 9, 10, 11, 12, 14, 15, 16, 17 and 18, 2011. The January 2011 MAR had no laxatives documented when Resident #22 failed to have a BM as per the facility’s BM protocol. Review of the February 2011 nurse aide care sheet had no BM documented on February 2, 3, 4, 5, 6, 7, 13, 14, 15, 17, 18, 19 and 20, 2011. The February 2011 MAR had no laxatives documented when Resident #22 failed to have a BM as per the facility’s BM protocol. The facility was unable to provide a nurse aide care sheet for March 2011. Review of the nurse’s notes dated 3/17/11 documented, "0 recorded BM x [times] 6 d [days]." This indicated Resident #22 had no BM for 6 days. Review of the nurse’s notes dated 3/24/11 documented "...resident on bed-side commode for appr. [approximately] 20 min [minutes] s [without] a BM. Resident had a BM @ [at] point of passing but it would not come out. Nurse tried to remove digitally... An enema was then administered s difficulty..."
During a telephone interview from the state office on 7/21/11 at 2:45 PM, the ADON confirmed that the facility was unable to locate the nurse aide care sheet for March 2011.

6. During an interview in the conference room on 7/20/11 at 4:00 PM, the Assistant Director of Nursing (ADON) was asked to explain the BM Protocol. The ADON stated, "...the nurses check the sheets [BM] and if no BM on the third day a standing order med [medication] is given."