F 279
SS=D
483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25, and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

Based on medical record review, facility document review, observation and interview, the facility failed to revise the care plan for the use of safety devices for two (#3, # 5) of eighteen residents reviewed.

The findings included:

Resident #3 was admitted to the facility on May 18, 1999, and re-admitted on June 26, 2010, with diagnoses including Episodic Mood Disorder, Congestive Heart Failure, Cerebral Vascular

F 279

"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Willow Ridge Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."

F 279

1. On June 27, 2012, the Clinical Case Manager corrected the Care Plan of Resident #3 to include the use of a concave mattress and to reflect that the active alarm has been discontinued.

On June 27, 2012, the Clinical Case Manager corrected the Care Plan of Resident #5 to include the use of a concave mattress for fall prevention. The bed alarm for Resident #5 discontinued on 1/26/12 was removed from the resident’s bed by nursing staff on 6/26/12.

2. On June 29, 2012, Nursing Management completed an audit of Care Plans of residents with falls in the past 90 days. Any Care Plans with issues were updated and corrected.
Continued From page 1
Accident, and Psychosis.

Review of the facility's documentation dated April 22, 2012, revealed, "Resident was getting into bed from the wheelchair and fell".

Observation on June 26, 2012, at 2:00 p.m., revealed the resident lying in bed on a concave mattress and the bed alarm attached to the resident.

Review of the current care plan revised on April 3, 2012, revealed the care plan had not been revised for the use of the concave mattress or bed alarm.

Interview with the Supervisor on June 26, 2012, at 10:15 a.m., at the nursing station, confirmed the care plan had not been revised for the use of the concave mattress or the bed alarm.

Resident #5 was admitted to the facility on January 18, 2012, with diagnoses including History of Falls, Urinary Retention, Atrial Fibrillation, Congestive Heart Failure, Early Dementia, Pernicious Anemia, and Encephalopathy.

Medical record review of the Physician Monthly Orders dated June 4, 2012, revealed, "Clip alarm on bed d/t (due to) unsteady gait and at risk for falls. Make sure (alarm is) in place and working order q (every) shift. 1/18/2012 (date ordered)."

Observation on June 25, 2012, at 8:00 a.m., and June 27, 2012, at 9:00 a.m., revealed the resident lying in bed with the bed alarm attached to the resident's gown.

3. The Staff Development Coordinator will complete re-education for licensed nurses and the Clinical Case Manager on the importance of updating the Care Plan with interventions with each fall by July 6, 2012.

4. Nursing Management will complete an audit for the Care Plan to assure fall investigation interventions have been added to the Care Plan twice weekly for 2 weeks, weekly for 2 weeks and monthly for 2 months. The monthly Performance Improvement Committee will review the audit results and make further recommendations as necessary to maintain substantial compliance. The Performance Improvement committee consists of the Administrator, Director of Nursing Services, Assistant Director of Nursing Services, Maintenance Director, Medical Director, Business Office Manager, Social Services Director, Activities Director, Admissions/Marketing Director, Environmental Services Director, Staff Development Coordinator, Nutritional Services Director, Health Information Manager, Therapy Program Manager, Clinical Case Manager, and MDS Coordinator.

7/9/12
### F 279

Continued From page 2

Review of the current care plan dated January 27, 2012, revealed the care plan had not been revised for the use of the bed alarm.

Interview with the Supervisor on June 25, 2012, at 1:00 p.m., at the nursing station, confirmed the resident had a history of falls and the care plan had not been revised for the use of the bed alarm ordered on January 18, 2012.

1. A bowel and bladder assessment was completed on Resident #3 by the clinical staff on July 2, 2012 through July 5, 2012, to assess current and physical functioning. Once completed the licensed nurse will choose a program based on the regulatory clarifications of urinary incontinence.

A bowel and bladder assessment was completed on Resident #5 by the clinical staff on July 2, 2012, through July 5, 2012 to assess current and physical functioning. Once completed the licensed nurse will choose a program based on the regulatory clarifications of urinary incontinence.

2. On July 2, 2012, Nursing Management completed an audit of other residents being admitted or having a change in continence in the past 90 days for the completion of a bowel and bladder assessment for urinary and physical function. Other residents affected based on this audit completed a bowel and bladder assessment by July 6, 2012.

3. The Staff Development Coordinator and Nursing Management will re-educate CNA's and licensed staff on completion of bowel and bladder assessments upon admission/re-admission and a change in urinary continence by July 6, 2012.
F 315 Continued From page 3

Congestive Heart Failure, Cerebral Vascular Accident, and Psychosis.

Medical record review of the Quarterly Minimum Data Set dated March 12, 2012, revealed the resident required no assistance with decision making, had no problem with memory, was independent with transfers, and was continent of bladder and bowel.


Medical record review revealed no documentation a bladder and bowel assessment had been completed.

Review of the facility's Continence Management Program revealed, "...The Licensed Nurse is responsible for developing an individual plan of care for the resident. This is completed by reviewing the resident's 72 hour voiding diary and current and physical functioning. Once the review is completed, the licensed nurse will choose a program based on the regulatory clarifications of the urinary incontinence definitions."

Interview with the Supervisor on June 26, 2012, at 1:00 p.m., at the nursing station revealed, "the resident has had episodes of incontinence since the pelvic fracture on April 22, 2012, and has recently requested briefs".

Observation and interview on June 26, 2012, at 3:00 p.m., revealed the resident lying in bed with

F 315 4. Nursing Management will complete a bowel and bladder assessment audit for newly admitted/re-admitted residents, and those that have had a change in urinary continence twice weekly for 2 weeks, weekly for 2 weeks and monthly for 2 months. The monthly Performance Improvement Committee will review the audit results and make further recommendations as necessary to maintain substantial compliance. The Performance Improvement Committee consists of the Administrator, Director of Nursing Services, Assistant Director of Nursing Services, Maintenance Director, Medical Director, Business Office Manager, Social Services Director, Activities Director, Admissions/Marketing Director, Environmental Services Director, Staff Development Coordinator, Nutritional Services Director, Health Information Manager, Therapy Program Manager, Clinical Case Manager, and MDS Coordinator.

7/9/12
**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier/Clinical Identification Number:** 445284

**Multiple Construction**

- **A. Building:**
- **B. Wing:**

**Date Survey Completed:** 06/27/2012

**Name of Provider or Supplier:** Willow Ridge Care and Rehabilitation Center

**Street Address, City, State, Zip Code:**
- 215 Richardson Way
- Maynardville, TN 37807

<table>
<thead>
<tr>
<th>ID TAG</th>
<th>Summary Statement of Deficiencies</th>
<th>ID PREFIX TAG</th>
<th>Provider's Plan of Correction</th>
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<td>F 315</td>
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Interview with the Supervisor on June 26, 2012, at 3:30 p.m., at the nursing station, confirmed the bladder and bowel assessment had not been completed after the resident started having episodes of incontinence.

Resident #5 was admitted to the facility on January 18, 2012, with diagnoses including History of Falls, Urinary Retention, Atrial Fibrillation, Congestive Heart Failure, Early Dementia, Pernicious Anemia, and Encephalopathy.

Medical record review of the Quarterly Minimum Data Set dated April 24, 2012, revealed the resident required moderate assistance with decision making, had short and long term memory problems, required total assistance with transfers, and was frequently incontinent of bladder and bowel.

Medical record review revealed no documentation of the bladder and bowel assessment had been completed.

Observation on June 25, 2012, at 10:00 a.m., revealed the resident lying in bed with eyes closed.

Medical record review of the Resident Functional Performance Reports for February through May, 2012, revealed the resident was incontinent daily.

Interview with the Supervisor on June 26, 2012, at 12:45 p.m., at the nursing station, confirmed the bladder and bowel assessment had not been
Continued From page 5 completed.

**F 329**
483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation, review of facility policy, and interview, the facility failed to administer medication as prescribed for one (#10) of eighteen residents reviewed.

The findings included:

**F 329**
1. On June 18, 2012, Nursing Management removed the Carvedilol medication out of the Medication cart for Resident # 10. Nursing Management notified the Resident’s physician, family and the pharmacy. Resident # 10 was observed for side effects by licensed nurse and had none.

2. On June 18, 2012, Nursing Management completed an audit of other residents having this medication ordered for mislabeling of the medication and no other issues were found. On June 21, 2012, the consultant pharmacist completed an audit of other residents’ medications and found no labeling issues.

3. The Staff Development Coordinator will complete re-education for the licensed nurses on the Medication Administration process by July 6, 2012.

4. The licensed nurse receiving the daily medication order will complete an audit to verify medication and the label match on each medication received and will sign the pharmacy delivery sheet twice weekly for 2 weeks, weekly for 2 weeks and monthly for 2 months. The consulting pharmacist will audit medication labeling during the monthly visit and report any issues found to the Director of Nursing Services for three months. The monthly Performance Improvement Committee will review the audit results and make further.
<table>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>recommendations as necessary to maintain substantial compliance. The Performance Improvement committee consists of the Administrator, Director of Nursing Services, Assistant Director of Nursing Services, Maintenance Director, Medical Director, Business Office Manager, Social Services Director, Activities Director, Admissions/Marketing Director, Environmental Services Director, Staff Development Coordinator, Nutritional Services Director, Health Information Manager, Therapy Program Manager, Clinical Case Manager, and MDS Coordinator.</td>
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Medical record review revealed resident #10 was readmitted to the facility on June 7, 2012, with diagnoses including Congestive Heart Failure, Atrial Fibrillation, Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease, and Hypertension.

Medical record review of the physician orders dated June 7, 2012, revealed "...Captopril (blood pressure medication) 25 milligrams (mg) by mouth twice a day everyday..."

Medical record review of the Interdisciplinary Progress Note dated June 18, 2012, at "...3P (3:00 p.m.) Nurse noted medication in box in med (medicine) cart to have wrong medication in box. Box had correct label on top of box for medication, however med in box & (and) label on side box was incorrect. Upon count, 13 tabs (tablets) were missing from box..."

Medical record review of the Medication Administration Record (MAR) scheduled for June 2012, revealed "...Captopril by mouth 25 mg start date 6/7/2012 twice a day everyday..." Further review revealed nursing initials beginning June 7, 2012, at 2000 (8:00 p.m.) through June 18, 2012, at 0800 (8:00 a.m.). Further review revealed on June 13, 2012, the nurse circled the initials and documented the resident was asleep.

Observation on June 26, 2012, at 9:35 a.m., with the Assistant Director of Nursing (ADON) present, of the label on top of the medication box revealed Captopril 25 mg. Further observation revealed the medication inside the box and the labels on the side and front of the box was
| F 329 | Continued From page 7  
Carvedilol (blood pressure medication) 25 mg. Further observation revealed thirteen of the sixty tablets of Carvedilol were missing from the box.  

Review of the facility policy entitled 6.0 General Dose Preparation and Medication Administration with the effective date of December 01, 2007, revealed "...Procedure...3. Prior to Medication Administration: 3.1 facility staff should verify each time a medication is administered that it is the correct drug,...5. After Medication Administration: 5.1 Facility should: 5.1.1 Document necessary medication administration/treatment information (e.g...when medications are given...if medications are refused...on appropriate forms..."  

Interview with the ADON on June 25, 2012, at 9:35 a.m., in the Director of Nursing office, confirmed the facility nursing staff initiated the MAR from June 7-18, 2012, and Captopril 25 mg had been administered. Further interview confirmed the circled initial on June 13, 2012, indicated the medication was not administered.  

Interview with the Director of Nursing (DON) on June 26, 2012, at 8:50 a.m., in the DON's office, confirmed the facility nursing staff administered thirteen tablets of Coreg (Carvedilol) 25 mg instead of the ordered Captopril. Further interview confirmed the facility nursing staff failed to follow the facility policy of verifying each time a medication was administered that the medication was correct.  

F 425 | 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  

The facility must provide routine and emergency
## Statement of Deficiencies and Plan of Correction

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### Name of Provider or Supplier

**Willow Ridge Care and Rehabilitation Center**

### Street Address, City, State, Zip Code

215 Richardson Way, Maynardville, TN 37807

### Summary Statement of Deficiencies

**F 425**

Continued from page 8, drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This **REQUIREMENT** is not met as evidenced by:

Based on medical record review, observation, and interview, the facility pharmacy failed to correctly label and provide prescribed medication for one (#10) of eighteen residents reviewed.

The findings included:

Medical record review revealed resident #10 was readmitted to the facility on June 7, 2012, with diagnoses including Congestive Heart Failure, Atrial Fibrillation, Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease, and Hypertension.

Medical record review of the physician orders...

### Provider's Plan of Correction

**F 425**

Medical Director, Business Office Manager, Social Services Director, Activities Director, Admissions/Marketing Director, Environmental Services Director, Staff Development Coordinator, Nutritional Services Director, Health Information Manager, Therapy Program Manager, Clinical Case Manager, and MDS Coordinator.

7/9/12
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| Continued From page 9 dated June 7, 2012, revealed "...Captopril (blood pressure medication) 25 milligrams (mg) by mouth twice a day everyday..." Medical record review of the Interdisciplinary Progress Note dated June 18, 2012, at "...3P (3:00 p.m.) Nurse noted medication in box in med (medicine) cart to have wrong medication in box. Box had correct label on top of box for medication, however med in box & (and) label on side box was incorrect..."

Observation on June 26, 2012, at 9:35 a.m., with the Assistant Director of Nursing (ADON) present, of the label on top of the medication box revealed Captopril 25 mg. Further observation revealed the medication inside the box and the labels on the side and front of the box was Carvedilol (blood pressure medication) 25 mg.

Interview with the pharmacist, by phone, on June 26, 2012, at 9:50 a.m., with the ADON present, confirmed the pharmacy had delivered Carvedilol 25 mg on June 7, 2012, instead of the prescribed Captopril 25 mg. | 1. Immediately, on June 25, 2012, Nursing Management removed for destruction any expired medications found in the refrigerator in the Central Medication Room, the Central Medication Room, Emergency Crash Cart, and Oxygen Supply Storage. On June 25, 2012, the licensed nurse applied a plastic break away lock to the Emergency medication box. On June 26, 2012, the licensed nurse applied a list of emergency medications and supplies in the Emergency crash cart. On June 25, 2012, the expired medications were immediately removed by the licensed nurse. On June 25, 2012, the licensed nurse immediately removed the expired 0.9% Sodium Chloride from the Oxygen storage room. 2. On June 25, 2012, Nursing Management observed other medication storage areas for expired medications. Any expired medications found were removed and stored for proper destruction.

3. The Staff Development Coordinator will complete re-education for the licensed nurses on dating, labeling, storage, and removal from use for destruction of expired medications by July 6, 2012. 4. Nursing Management will complete an audit for medication expiration twice weekly for 2 weeks, weekly for 2 weeks and monthly for 2 months. The monthly... |
F 431 Continued From page 10
labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 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 observation, review of the facility's policy, review of Tennessee Pharmacy Laws 2011 Edition, and interview, the facility failed to dispose of expired medications in three (Central Medication Room, Emergency Crash Cart, Oxygen Supply Storage Room) of eight medication storage areas observed; failed to secure the contents of emergency medications for residents in one (Orange First Dose Emergency Kit) of two emergency kits (boxes) observed; and failed to list all emergency medications available in one (Emergency Crash
Continued From page 11
Cart of one emergency crash cart observed.

The findings included:

Refrigerator in the Central Medication Room

Observation of the contents of the refrigerator on June 25, 2012, at 9:30 a.m., in the Central Medication Room on the West 2 Hall, with Licensed Practical Nurse (LPN) #1, revealed nine, AH gel syringes for topical application. Further observation revealed the medications in the nine gel syringes expired on April 24, 2012. The letters, AH, are the first letters of the two medications (Ativan [control substance medication for anxiety] and Haloperidol [antipsychotic medication]) in each AH syringe.

Observation of the contents of the refrigerator on June 25, 2012, at 9:30 a.m., in the Central Medication Room on the West 2 Hall, with LPN #1, revealed two, ABHRP gel syringes for topical application for Resident #4. Further observation revealed the medications in the two gel syringes expired on March 7, 2012. The letters, ABHRP, are the first letters of the five medications (Ativan [control substance medication for anxiety]; Benadryl [anti-histamine medication]; Haloperidol [antipsychotic medication]; Reglan [medication for nausea]; and Promethazine [anti-histamine medication for nausea]) in each ABHRP syringe.

Review of the facility’s policy, “Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles” revealed, “...The Facility should ensure that drugs and biologicals that: (1) have an expired date on the label...are stored separate from other medications until destroyed..."
Continued From page 12

Interview with LPN #1 on June 25, 2012, at 9:35 a.m., in the Central Medication Room on the West 2 Hall, confirmed the medications in the AH gel syringes and the ABHRP gel syringes were expired and available for use.

Central Medication Room

Observation in the Central Medication Room on June 25, 2012, at 9:40 a.m., on the West 2 Hall, with LPN #1, revealed two packages of Famotidine (medication for stomach) 10 milligram (mg) containing 30 tablets each. Further review revealed both packages of Famotidine expired in April, 2012.

Review of the facility's policy, "Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles" revealed, "...The Facility should ensure that drugs and biologicals that: (1) have an expired date on the label...are stored separate from other medications until destroyed..."

Interview with LPN #1 on June 25, 2012, at 9:45 a.m., in the Central Medication Room on the West 2 Hall, confirmed the two packages of Famotidine 10 mg tablets were expired and available for use.

Unsecured Emergency Box

Observation of the Orange First Dose Emergency Kit on June 25, 2012, at 9:40 a.m, in the Central Medication Room in the West 2 Hall with LPN #1, revealed the box was unlocked. Further observation of the list of contents on the outside of the kit revealed 906 units of 151 medications
Continued From page 13

requiring physician orders were available for emergency use for residents. The list included antibiotic medications (Cephalexin); medications for blood pressure (Metoprolol); antipsychotic medications (Quetiapine); diabetic medications (Glipizide); and blood thinner medications (Warfarin).

Review of the facility's policy, "Interim/Stat/Emergency Supply of Medications" revealed, "...Emergency boxes...Facility should ensure that emergency boxes remain on the nursing unit until either an item is withdrawn or one of its contents is about to expire. In either case, Facility should contact the Pharmacy for a replacement..."

Review of the Tennessee Pharmacy Laws 2011 Edition Rule 1140-4-.09 "EMERGENCY AND HOME CARE KITS" (page 210) documented "... (3) The emergency kit shall be provided sealed or electronically secured by authorized personnel in accordance with established policies..."

Interview with LPN #1 on June 25, 2012, at 9:45 a.m., in the Central Medication Room on the West 2 Hall, confirmed the following: the emergency box was unlocked; the contents were not secured; and the pharmacy had not been notified.

Emergency Crash Cart

Observation of the Emergency Crash Cart on June 25, 2012, at 2:45 p.m., outside the Main Nursing Station, with Registered Nurse (RN) #1, revealed the expiration date of the Emergency Crash Cart was not on the outside of the cart and
Continued From page 14

the list of items, contained within the cart, was not readily accessible. Further observation revealed the following medications were expired and not on the list of items contained within the cart: one, 100 milliliter (ml) bottle of Sterile 0.9% Sodium Chloride Solution with expiration date of September 2009; two, 110 ml bottles of Sterile 0.9% Sodium Chloride Solution with expiration dates of May 2012; and four, 5 ml 0.9% Sodium Chloride Solution with expiration dates of September 2011.

Review of the facility's policy, "Interim/Stabil/Emergency Supply of Medications" revealed, "...Facility should ensure that all boxes contain a list of the contents..."

Review of the Tennessee Pharmacy Laws 2011 Edition Rule 1140-4-.09 "EMERGENCY AND HOME CARE KITS" (page 210) documented "...3...The expiration date of the kit shall be clearly marked on the exterior of the kit to represent the earliest expiration date of any drug, device, or related materials contained in the kits...

A list of the emergency kit contents shall be readily accessible and it shall include the drugs, devices, and related materials contained therein and include the name (trade and/or generic), strength, and quantity of the products contained therein...

Review of the facility's policy, "Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles" revealed, "...The Facility should ensure that drugs and biologicals that: (1) have an expired date on the label...are stored separate from other medications until destroyed..."

Interview with RN #1 on June 25, 2012, at 2:50
**Willow Ridge Care and Rehabilitation Center**

**SUMMARY STATEMENT OF DEFICIENCIES**

Continued from page 15 p.m., at the Emergency Crash Cart outside the Central Nursing Station, confirmed the following: the expiration date was not on the outside of the cart; the list of items, contained within the cart, was not readily accessible; and the 0.9% Sodium Chloride Solutions were expired and not documented on the list of items available in the cart.

**Oxygen Supply Storage Room**

Observation in the Oxygen Supply Storage Room on June 25, 2012, at 2:55 p.m., with RN #1, revealed ninety-two, 5 ml 0.9% Sodium Chloride solutions. Further observation revealed the solutions expired on September 2011.

Review of the facility's policy, "Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles" revealed, "...The Facility should ensure that drugs and biologicals that: (1) have an expired date on the label...are stored separate from other medications until destroyed..."

Interview with RN #1 on June 25, 2012, at 3:00 p.m., in the Oxygen Supply Storage Room, confirmed the Sodium Chloride solutions were expired.

483.75(l)(1) RES

**RECORDS-COMPLETE/ACCURATE/ACCESSIBLE**

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.

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**Corrective Plan**

- **F 431**
  - On June 26, 2012, the Director of Nursing Services verified the physician order for Resident # 2's tube feeding rate and totals for Intake and Output.
  - On June 29, 2012, Nursing Management completed an audit of other residents with tube feedings for correct rate and Intake and Output recordings. No other issues were found.
  - The Staff Development Coordinator will re-educate the licensed staff on the process to accurately obtain Intake and Output by July 6, 2012.
  - Nursing Management will complete an Intake and Output audit for residents that have tube feedings twice weekly for 2 weeks, weekly for 2 weeks and monthly for 2 months. The Performance Improvement Committee will review the audit results and make further recommendations as necessary to maintain substantial compliance. The monthly Performance Improvement committee consists of the Administrator, Director of Nursing Services, Assistant Director of Nursing Services, Maintenance Director, Medical Director, Business Office Manager, Social Services Director, Activities Director, Admissions/Marketing Director, Environmental Services Director, Staff Development Coordinator, Nutritional Services Director, Health Information Manager, Therapy Program
**F 514** Continued From page 16

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, review of facility Tube Feeding Guidelines, and interview, the facility failed to ensure an accurate clinical record was maintained for one resident (#2) of eighteen residents reviewed.

The findings included:

Resident #2 was admitted to the facility on January 25, 2012, with diagnoses including Cerebral Vascular Accident, Human Immunodeficiency Virus, Gout, Congestive Heart Failure, Dysphasia, Psychosis, Diabetes, and Hypertension.

Review of Physician's monthly orders for June, 2012, revealed an order for tube feeding of Glucerna 1.2 to run at 70 cc (cubic centimeters) an hour (approximately 560 cc per shift), for 22 hours every day. On June 14, 2012, the Physician ordered an increase in the tube feeding rate to 80 cc per hour, for 22 hours per day (approximately 640 cc per shift).

Medical Record review of the Intake and Output (I&O) Record from June 14 through June 25, 2012, revealed inaccurate tube feeding volume documentation for fourteen out of twenty eight
F 514

Continued From page 17

entries, and ten of twenty eight entries were missing.

Review of the Facility's Tube feeding Guidelines
#20 revealed "...Review all I&O documentation: is
fluid intake recorded every shift and totaled every
24 hours. Are actions taken when fluid needs are
not met?..."

Interview with the Director of Nursing (DON) on
June, 26, 2012, at 9:00 a.m., at the nurse's
station, confirmed the I&O's were to be done daily
at the end of each shift, the documentation on the
I&O records were incorrect, and there were 10 of
28 entries missing.