<table>
<thead>
<tr>
<th>ID</th>
<th>PREMIX</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 241</td>
<td>SS-D</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NUMBER STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION</td>
<td>EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY</td>
</tr>
</tbody>
</table>

**F 241**

The facility will promote care for residents in a manner and an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

Privacy will be maintained by taking residents to their rooms for any resident requiring fingersticks and/or insulin injections. The privacy curtain will be pulled or the door closed to maintain privacy.

An in-service was given by Judy Beckham, RN/DON and JoAnn Staton, RN/ADON regarding fingersticks, insulin administration, and privacy (see attached).

These will be routinely monitored by administrative nursing staff (DON, ADON, RN Supervisor).

**The findings included:**

1. Observations in RR #1's room on 8/9/10 at 4:15 PM, revealed Nurse #2 entered RR #1's room, did not close the curtains or close the door and performed a fingerstick blood sugar check on RR #1.

2. Observations in Resident #9's room on 8/9/10 at 4:22 PM, Nurse #2 entered Resident #9's room, did not close the curtains or the door and performed a fingerstick blood sugar check on Resident #9. Nurse #2 returned to the medication cart and prepared sliding scale insulin. Nurse #2 entered Resident #9's room again, did not close the curtains or the door and administered the insulin into Resident #9's left arm.

3. During an interview in the Director of Nursing's (DON) office on 8/10/10 at 3:00 PM, when asked how would you expect a nurse to provide privacy.

---

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 patients. (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.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>44E306</td>
<td>A. BUILDING:</td>
</tr>
<tr>
<td></td>
<td>B. WING:</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

WAYNE CARE NURSING HOME

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

605 SOUTH HIGH STREET
WAYNESBORO, TN 38485

**ID PREFIX TAG**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>ID PREFIX TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 241</td>
<td>F 241</td>
</tr>
</tbody>
</table>

Continued From page 1 during the medication pass the Assistant Director of Nursing stated, "Close the curtains" and the DON stated, "And close the door."

**F 280**

483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 280</td>
<td>F 280</td>
<td></td>
</tr>
</tbody>
</table>

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on medical record reviews and interviews, it was determined the facility failed to revise the comprehensive care plan to reflect the residents' current status for 3 of 14 (Residents #6, 7 and 8) sampled residents.

The findings included:

1. Medical record review for Resident #6

A comprehensive care plan will be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

A comprehensive care plan was developed for Resident #6 that reflects their current status for a seizure (see attached).
F 280  Continued From page 2

documented an admission date of 11/1/02 and a re-admission date of 3/11/10 with diagnoses of Alzheimer’s Disease, Right Hemiparesis, Seizure Disorder and Congestive Heart Failure. Review of the current care plan dated 5/14/10 did not address a plan of care for seizure activity.

During an interview in the Director of Nursing’s (DON) office on 6/10/10 at 9:45 AM, the DON was asked if she would expect Resident #6 to have a care plan for seizures. The DON stated, “She’s [Resident #6] had that diagnosis [seizure disorder] since she came here several years ago. It should be on the care plan.” The DON reviewed the care plan and stated, “I don’t see it [care plan for seizure activity].” It didn’t print out. It should have been written in.”

2. Medical record review for Resident #7 documented an admission date of 6/18/07 with diagnoses of End Stage Alzheimer’s Disease, Hypertension, and Seizure Disorder. Review of a physician’s order dated 8/14/10 documented, “...MONITOR FOR SEIZURE ACTIVITY...” Review of the current care plan dated 8/5/10 did not address a plan of care for seizure activity.

During an interview in the Assistant Director of Nursing’s (ADON) office on 8/10/10 at 2:05 PM, the ADON was asked about a care plan for seizures. The ADON stated, “Sure don’t have one for seizures.”

3. Medical record review for Resident #8 documented an admission date of 3/22/05 and a re-admission date of 3/4/08 with diagnoses of Alzheimer’s Disease, Seizure Disorder, and Mental Retardation. Review of the care plan dated 2/5/10 did not address seizure activity.

A comprehensive care plan was developed for Resident #7 that reflects their current status for a seizure disorder (see attached).

A comprehensive care plan was developed for Resident #8 that reflects their current status for a seizure disorder (see attached). Care plans will be monitored by JoAnn Statom, RN/ADON.
During an interview in the DON's office on 8/10/10 at 2:10 PM, the DON was asked if Resident #8 had interventions on the care plan for seizures. The DON stated, "I don't see it. I'll get it fixed."

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record reviews, observations and interviews, it was determined the facility failed to ensure that peri-care was performed in a manner to prevent the development of a possible urinary tract infection for 2 of 2 (Residents #1 and 9) sampled residents observed receiving peri-care.

The findings included:

1. Review of the facility's "Peri Care" policy documented, "For females: ... 4. Wash pubic area, separate the labia and wash downward on each side of the labia using different corners of the washcloth. Wash downward in the middle over the urethra and vaginal openings..."

Based on the resident's comprehensive assessment, the facility will ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

The facility policy for peri-care was updated to reflect the use of a barrier to prevent contamination. An inservice was given by Charlene Overton, RN/Supervisor to the certified nursing aides on correct peri-care and the policy changes (see attached).
### Statement of Deficiencies and Plan of Correction

#### F315

**Summary Statement of Deficiencies**
- **F315** Continued From page 4

**Provider's Plan of Correction**
- Certified nursing aides will be routinely monitored for the correct procedure of providing peri-care by the nursing staff.

**Observations**
- Resident #1 visited on 8/10/10 at 9:45 AM, revealed Certified Nursing Assistant (CNA) #1 performed peri-care on Resident #1. CNA #1 washed down the middle of Resident #1's vaginal area without separating the labia.

- During an interview on the 100 hall on 8/10/10 at 2:00 PM, when asked about the peri-care, CNA #1 stated, I didn't spread it [the labia] open and I should have.

2. Medical record review for Resident #9 documented an admission date of 6/17/07 with diagnoses of Diabetes Mellitus, Hypertension, Peripheral Vascular Disease, Osteoarthritis, and Urinary Tract Infection.

- Observations in Resident #9's room on 8/10/10 at 1:25 PM, revealed CNA #2 performed peri-care on Resident #9. CNA #2 placed clean, wet washcloths on the siderail of bed, then proceeded to use these washcloths to perform peri-care on Resident #9. The placing of the wet washcloths on the siderail, contaminated the washcloths with the potential for the development of a urinary tract infection.

- During an interview on the 100 hall on 8/10/10 at 2:30 PM, CNA #9 confirmed that she placed the washcloths on the siderail of the bed.

---

**SSD**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F315</td>
<td></td>
<td></td>
<td>Certified nursing aides will be routinely monitored for the correct procedure of providing peri-care by the nursing staff.</td>
</tr>
</tbody>
</table>

**Event ID:** F58911

**Facility ID:** TN9101

If continuation sheet Page 5 of 11
**F 318** Continued From page 5

Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

This REQUIREMENT is not met as evidenced by:

Based on medical record reviews and interviews, it was determined the facility failed to ensure 2 of 8 (Residents #7 and 8) residents with limited range of motion (ROM) received appropriate treatment to prevent further decrease in ROM.

The findings included:

1. Medical record review for Resident #7 documented an admission date of 5/18/07 with diagnoses of End Stage Alzheimer's Disease, Hypertension, and Seizure Disorder. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/5/10 for section 2-memory-coded Resident #7 as 1-1, indicating the resident had problems with short and long term memory; section B4-cognitive skills for daily decision making skills, coded the resident as a 3-indicating he was severely impaired in decision making skills; and section-G4 functional limitations in ROM coded the resident as 2-1 for a through e, indicating the resident had limitations in ROM on both sides of his body with partial loss of involuntary movement in his neck, arms, hands, legs and feet. Review of the comprehensive care plan dated 8/5/10 documented, "Problem: Resident is at risk for skin breakdown R/T [related to] decreased..."
**Wayne Care Nursing Home**

**Street Address, City, State, Zip Code**

605 South High Street
WAYNESBORO, TN 38485

<table>
<thead>
<tr>
<th><strong>ID Prefix Tag</strong></th>
<th><strong>Summary Statement of Deficiencies</strong></th>
<th><strong>ID Prefix Tag</strong></th>
<th><strong>Provider's Plan of Correction</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>F 318</td>
<td>Continued From page 6 mobility, inability to manage ADLs [Activities of Daily Living] and incontinence... Approach... Encourage physical activity, mobility, and range of motion to maximal potential...&quot;</td>
<td>F 318</td>
<td>A comprehensive care plan 8/10/10 was updated to reflect the needs of the resident to have range of motion exercise, provided by the nursing staff (see attached). Care plans will be monitored by JoAnn Statom, RN/ADON.</td>
</tr>
</tbody>
</table>

During an interview in the Assistant Director of Nursing's (ADON) office on 8/10/10 at 2:05 PM, the ADON was asked about the care plan for Resident #7's limitations in ROM. The ADON stated, "I need to take that off, he has no potential."

2. Medical record review for Resident #8 documented an admission date of 3/22/05 and a re-admission date of 3/4/08 with diagnoses of Alzheimer's Disease, Seizure Disorder, and Mental Retardation. Review of the quarterly MDS dated 8/5/10 for section B2-memory coded Resident #8 as 1-1, indicating she had problems with short and long term memory; section B4-cognitive skills for daily decision making, coded Resident #8 as a 3-indicating she was severely impaired in decision making skills; section-G4 functional limitation in ROM coded the resident as 1-1 for b, indicating the resident had limitations in arms including shoulder or elbow with partial loss. Review of the care plan dated 8/5/10 documented, "...Problem: Resident is at risk for skin breakdown R/T decreased mobility, Approach... Encourage physical activity, mobility, and range of motion to maximal potential..."

During an interview in the DON's office on 8/10/10 at 2:10 PM, the DON was asked how you expect the staff to encourage Resident #8 to perform ROM to her maximum potential. The DON stated, "You can't do that with her. She doesn't understand. She's not capable. I'll get that fixed on the care plan."
Based on the comprehensive assessment of a
resident, the facility must ensure that a resident
who is fed by a naso-gastric or gastrostomy tube
receives the appropriate treatment and services
to prevent aspiration pneumonia, diarrhea,
vomiting, dehydration, metabolic abnormalities,
and naso-pharyngeal ulcers and to restore, if
possible, normal eating skills.

This REQUIREMENT is not met as evidenced
by:
Based on medical record reviews, observations
and an interview, it was determined the facility
failed to label all containers of formula with the
resident's name, date, rate and time hung for 3 of
3 (Residents #1, 7 and 8) sampled residents
receiving enteral nutrition.

The findings included:

1. Medical record review for Resident #1
documented an admission date of 1/22/04 with
diagnoses of Diabetes Mellitus, Hypertension,
Hypercholesterolemia and Urinary Retention with
Urinary Tract Infection (UTI). Review of a
physician's order dated 5/27/10 documented,
"...JEVITY WITH FIBER (1.06) FORMULA @ [at]
55ml [milliliters] / [per] hr [hour] x [times] 22 hrs..."

Observations in Resident #1's room on 8/9/10 at
10:00 AM, 11:20 AM, 1:05 PM, 2:50 PM and 4:39
PM, revealed Resident #1's container of Jevity
with fiber formula was not labeled with the
residents name, date, rate or time hung.

2. Medical record review for Resident #7

The container of Jevity formula for Resident #1 was
labeled with the resident's name, date, rate, and time
hung by Susan Perry, LPN.
**Wayne Care Nursing Home**

<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>F 322</strong></td>
<td></td>
<td>Continued From page 8 documented an admission date of 5/18/07 with diagnoses of End Stage Alzheimer's Disease, Hypertension and Seizure Disorder. Review of a physician's order dated 8/14/10 documented, ...ISOsource 1.5 @ 50ML/HR VIA PUMP... Observations in Resident #7's room on 8/9/10 at 9:41 AM, 11:15 AM, 1:05 PM, 2:50 PM and 4:50 PM revealed Resident #7's container of Isosource 1.5 calorie (cal) formula was not labeled with the resident's name, date, rate or time hung.</td>
<td><strong>F 322</strong></td>
<td>The container of Isosource formula for Resident #7 was labeled with the resident's name, date, rate, and time hung by Ashley Dugger, LPN.</td>
<td></td>
</tr>
</tbody>
</table>
| **3.** Medical record review for Resident #8 documented an admission date of 5/13/09 with diagnoses of Alzheimer's, Demencia, Osteoporosis and Seizure Disorder. Review of a physician's order dated 7/8/10 documented, ...ISOsource 1.5 @ 40cc [cubic centimeters] /HOUR x 20 HOURS... Observations in Resident #8's room on 8/9/10 at 10:03 AM, 11:16 AM, 1:07 PM, 2:55 PM and 4:30 PM revealed Resident #8's container of Isosource 1.5 cal formula was not labeled with the resident's name, date, rate or time hung. | | During an interview in the Director of Nursing (DON) office on 8/10/10 at 11:35 AM, the DON stated, "It [referring to container of formula] should be labeled with the resident's name, date, rate and the time hung."

| **F 333** | 483.26(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS | | | The facility will ensure that residents are free of any significant medication errors. |
| **SS=0** | | The facility must ensure that residents are free of any significant medication errors. | | |

---

**Notes:**
- Form CMS-2567(02-99) Previous Versions Obsolete
- Event ID: P66911
- Facility ID: TN9101
- If continuation sheet Page 9 of 11
<table>
<thead>
<tr>
<th>F 333 Continued From page 9</th>
<th>F 333</th>
</tr>
</thead>
<tbody>
<tr>
<td>This REQUIREMENT is not met as evidenced by:</td>
<td>Insulin administration will be administered within the proper time frame before meals.</td>
</tr>
<tr>
<td>Based on review of the med-pass common insulins provided by the American Society of Consultant Pharmacists, policy review, medical record review, observation and interview, it was determined the facility failed to ensure that residents were free of significant medication errors when 1 of 2 nurses (Nurse #2) observed during insulin administration failed to administer insulin within the proper time frame before meals for 1 of 1 (Resident #9) sampled residents.</td>
<td>Insulin injections will be given as meal trays come out from the dietary department or with the meal to prevent possible hypoglycemic reaction. The policy for insulin administration was updated.</td>
</tr>
<tr>
<td>The findings included:</td>
<td>An inservice was given to the nursing staff by Judy Beckham, RN/DON, and JoAnn Statom, RN/ADON on the proper insulin administration and the policy change. (see attached).</td>
</tr>
</tbody>
</table>
| Review of the "MED-PASS COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties" provided by the American Society of Consultant Pharmacists for typical dosing administration of insulin related to meals documented, 
  "...NOVOLIN R... ONSET (in hours, Unless Noted)... 0.5- [to] 1 (hours)... 30 minutes before meals."
| Review of the facility's "Administration of Insulin" policy documented, 
  "...3. Insulin will be given 30 minutes before meals or per physician order..."
| Medical record review for Resident #9 documented an admission date of 5/17/07 and re-admission date of 5/28/10 with diagnoses of Non Insulin Dependent Diabetes Mellitus, Peripheral Vascular Disease, and Coronary Artery Disease. Review of the physician's orders dated 7/14/10 documented, 
  "...NOVOLIN-R [Regular] 100 UNIT/ [per] ML [milliliter]. W [with] / SSI [sliding scale insulin]: ...161-240= [amount of insulin to be administered] 2U [units]..." |
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 333</td>
<td>Continued From page 10</td>
<td></td>
<td>Observations in Resident #9's room on 8/9/10 at 4:22 PM, revealed Nurse #2 administered Novolin R 2 units to Resident #9. Resident #9 was not served her evening meal until 5:10 PM, which was 48 minutes after the resident received the insulin.</td>
<td>F 333</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>During an interview at the nurse's station on 8/10/10 at 9:40 AM, Nurse #2 was asked what is the time frame for administering SSI before a meal. Nurse #2 stated, &quot;We give at 30 minutes, or try to.&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>