Wayne County Nursing Home files this Plan of Correction solely to satisfy State and Federal mandates. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through the Informal Dispute Resolution, Formal Appeal, and any other applicable legal or administrative proceeding. This Plan of Correction should not be taken as establishing a standard of care and the facility submits that the actions taken by it in response to the survey findings establish an acceptable standard of care. This document is not intended to waive any defense, legal or equitable, in any proceeding, administrative, civil, or criminal.

F280
483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
The facility will assure the resident has the right to participate in planning care and treatment or changes in care and treatment. 

1. Resident #51's Care Plan was updated on 11/12/13 by Resident.

F280
483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
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 policy review, review of an accident report, medical record review, observation and interview, it was determined the facility failed to revise the care plan for a fall or a change in siderall usage for 2 of 11 (Residents #51 and 99) sampled residents reviewed of the 23 residents included in the stage 2 review.

The findings included:
1. Review of the facility's "FALL PREVENTION" policy documented, "...Update care plan quarterly or more frequently if needed."
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<tr>
<th>F 280</th>
<th>Continued From page 1</th>
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<tbody>
<tr>
<td></td>
<td>Medical record review for Resident #51 documented an admission date of 2/11/2006 with diagnoses of Hypertension, Depression, Attention to Colostomy, Seizure Disorder, Osteoarthritis, Anxiety, Mental Retardation, Chronic Obstructive Pulmonary Disease. The care plan dated 9/23/13 was not updated to include an intervention for a fall on 11/9/13.</td>
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<td>Review of an incident / accident report dated 11/9/13 documented Resident #51 had a fall with no injuries noted.</td>
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<td>F 280</td>
<td>Care Coordinator. Resident #99's Care Plan was updated on 11/13/13 by Resident Care Coordinator.</td>
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<td>2. As all resident's have potential to be affected if CP isn't updated timely, the following steps have been taken:</td>
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<td>The DON conducted a written inservice on 11/25/13 for LPNs and RNs regarding timely update of CP after falls, changes in siderail usage, etc.</td>
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<td>The ADON will review with LPNs and RNs to assure understanding and compliance during the Nurse Meetings on November 26, 27, 29.</td>
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<td>ADON and RCC completing audit by 12/4/13 to assure all CPs are current with falls, interventions, changes in siderails, etc.</td>
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<td>The Administrator created a mandatory Silverchair Learning Sys. session for all staff covering timely CP updates on falls, siderails, etc. in addition to all other tags. Deadline for completion by all staff is 12/6/13.</td>
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<td></td>
<td>3. The LPNs and RNs will update Care Plans as needed following incidents or changes. The RCC will follow-up, using I&amp;As and/or doctor's orders, to assure that CPs have been updated timely.</td>
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Observations in Resident #99's room on 11/12/13 at 12:25 PM and 11/13/13 at 7:55 AM, revealed Resident #99 lying in the bed on her back with 3/4 siderails were up x 2.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 280</td>
<td>Continued From page 2. During an interview in conference room on 11/13/13 at 2:00 PM, the Director of Nursing (DON) was asked about the siderails up x 2 on Resident #99's care plan. The DON confirmed the care plan was not updated and stated, &quot;...she [Resident #99] requested 2 siderails after her cataract surgeries, do not see where has been updated [care plan]... she uses 2 siderails...&quot;</td>
<td>F 280</td>
<td>4. A QA Action Plan has been done on 11/25/13 by the Administrator and presented to the QA Committee on 11/26/13. The DON and ADON will conduct routine checks/audits to assure compliance. Findings will be reported back to QA Committee weekly for next 3 months.</td>
<td>12/6/13</td>
</tr>
<tr>
<td>F 332 (SS=D)</td>
<td>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.</td>
<td>F 332</td>
<td>F332 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE. The facility will ensure that it is free of medication error rates of 5% or greater.</td>
<td>12/6/13</td>
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<td></td>
<td>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined 1 of 4 (Nurse #2) medication nurses failed to administer medications with a medication error rate of less than 5 percent (%). A total of 2 errors were observed out of 26 opportunities for error, resulting in a medication error rate of 7.692307%.</td>
<td></td>
<td>1. Nurse #2, responsible for direct care of affected residents, has been inserviced on 11/20/13 by the DON on facility's policy for administering eye drops.</td>
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<td>The findings included: 1. Review of the facility's &quot;Eye Drop Administration Procedure&quot; policy documented, &quot;...Gently pull the lower eyelid down from the eye to form a pouch... Instill the drop inside the lower eyelid... after instilling the drop, slowly release the eyelid and instruct the patient to slowly close eyes to allow for even distribution of the drop over the eye...&quot;</td>
<td></td>
<td>2. As all residents have the potential to be affected in the future if drops are not administered according to facility policy, the following action has been taken: All LPNs and RNs have been inserviced on 11/20/13 by the ADON on facility's policy for</td>
<td></td>
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<tr>
<td>(X4) ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
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<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td>OCS COMPLETION DATE</td>
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| F 332             | Continued From page 3  
2. Medical record review for Resident #99 documented an admission date of 1/25/13 with diagnoses of Multiple Back Fractures, Left Supraclavicular Mass, Thrombocytopenia, Pacemaker, Coronary Artery Disease, Enlarged Thyroid, Hypertension, Anemia, Osteoporosis, Left Carotid Stenosis, Renal Insufficiency, Constipation, Congestive Heart Failure, Hepatic Encephalopathy, Cirrhosis, Chronic Kidney Disease Stage 3, Cholelithiasis and Chest Mass. Review of the physician's orders dated 9/28/13 documented, "...SYSTANE BALANCE 0.6% EYE PLACE 1 DROP INTO BOTH EYES 4 TIMES DAILY..."  
Observations in Resident #99's room on 11/13/13 at 12:30 PM, while administering Systane eye drops, Nurse #2 lifted the left upper eyelid and administered two drops that missed the eye and the third drop went into the eye, but she failed to make a pouch with the lower lid as the policy states. The failure to administer eye drops by making a pouch with the lower lid resulted in medication error #1.  
3. Medical record review for Resident #95 documented an admission date of 4/5/13 with diagnoses of Peptic Ulcer Disease, Esophageal Reflux, Osteoporosis, Dementia, Anxiety, Depression, Constipation, Insomnia, Memory Loss, Joint Pain, Hypertension and Hypercholesterolemia. Review of the physician's orders dated 1/6/13 documented, "...Tobradex...i [1] gtt [drop] QID [four times a day]..."  
Observations in Resident #95's room on 11/13/13 at 12:42 PM, while administering Tobradex eye drops, Nurse #2 lifted the left upper eyelid and placed a drop into the eye and failed to make a | F 332 | administering eye drops.  
Eye Drop administration was added to Administrator's Silverchair Session created. It is mandatory for all employees to complete training session by 12/6/13.  
The DON and ADON will observe all eye drop administration and complete a check-off form for nurses to assure proper application. This was started on 11/25/13 and will be completed by 12/6/13.  
3. The Pharmacy Consultant will observe med pass during next 3 scheduled visits, and will observe LPN #2 each visit, to ensure continued understanding and compliance.  
4. A QA Action Plan has been done and presented to QA Committee for approval by the Administrator.  
The DON and ADON will conduct random weekly med pass reviews and will report back to QA Committee the outcomes.  
The QA Committee will continue to monitor results for 3 months.  
12/6/13 |
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

WAYNE COUNTY NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

104 J V MANGUBAT DRIVE, PO BOX 510

WAYNESBORO, TN 38485

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

X ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

Completion Date

F 332
Continued From page 4
pouch with lower lid as the policy states. The failure to administer eye drops by making a pouch with the lower lid resulted in medication error #2.

4. During an interview in the Director of Nursing's (DON) office on 11/14/3 at 12:02 PM, the DON was asked what was the procedure for administering eye drops. The DON stated, "...hold lower lid with gloved finger and put drop in the pouch..."

F 371
483.35(I) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on policy review, observation and interview, it was determined the facility failed to ensure food was prepared and served under sanitary conditions when 8 of 16 staff members (Certified Nursing Assistant (CNA) #1, 2, 3 and 4, Feeding Assistant (FA) #1, Nurses #3 and 4 and Maintenance Worker #1) failed to practice proper hand hygiene by handling food items with bare hands or entered the kitchen where food was being served on the tray line without wearing a hair covering.

F 371
483.35(I) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

Facility will store, prepare, distribute and serve food under sanitary conditions.

1. CNAs #1,2,3, and 4, FA #1, Nurse #3 and 4 were inserviced by DON and ADON on properly assisting with resident's straw, utensils, and food without using bare hands and on properly sanitizing of hands.

Maint. #1 was inserviced by supervisor on 11/14/3 on wearing proper hair covering when entering the kitchen.

2. As all residents have the potential to be affected, the following action has been taken:

All staff serving trays and/or assisting with meals have been inserviced by ADON on 11/18/13 on proper hand-hygiene, not touching food or straw or utensils with bare hands. All facility staff was inserviced by Administrator on 11/14/13 regarding no one entering kitchen without proper hair covering.

Hand-Hygiene and hair coverings in kitchen were added to the Silverchair Learning session created by Administrator 11/25/13. It is a mandatory session that must be
F 371 Continued From page 5

The findings included:

1. Review of the facility's "HAND HYGIENE" policy documented, "...Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene... before and after direct resident contact..."

Review of the facility's "Use of Gloves..." policy documented, "...PURPOSE: To prevent the spread of bacteria that may cause food borne illnesses... when preparing or handling food..."

F 371 completed by all employees by 12/6/13.

3. Tray service for employee meals was revamped on 11/15/13. The trays are now prepared and put on a cart at doorway to dining room. No employee needs to enter the kitchen now to get a meal tray.

The DON, ADON, RCC, and the Administrator will make random observations of meal times (in dining room and resident rooms) to ensure compliance of hand-hygiene practices.

4. A QA Action Plan was completed and presented to QA Committee on 11/25/13 by the Administrator.

Administrator will routinely monitor dining room, resident rooms, and the kitchen area during meals to ensure continued compliance.

Outcomes will be reported back to the QA Committee for the next 3 months.

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F 371 continued from page 5.

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Outcomes will be reported back to the QA Committee for the next 3 months.
<table>
<thead>
<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F371</td>
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<td>F371</td>
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<td></td>
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<td>peeled a banana and handed it to a resident with her bare hands touching the banana.</td>
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<td>e. Observations in the main dining room on 11/12/13 at beginning at 12:20 PM, Nurse #3 picked up a resident's eyeglasses off the table and put them on the resident's face, then picked up 1/4 of a sandwich with her bare hand and handed it to the resident.</td>
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<td>f. Observations in the main dining room on 11/12/13 at beginning at 12:20 PM, Nurse #4 touched a resident's clothing protector to straighten it, then picked up a cheese puff and handed it to the resident.</td>
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<td>d. FA #1 cut a ham and cheese sandwich in half and handed it to a resident with her bare hand.</td>
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<td>During an interview in the Director of Nursing's (DON) office on 11/4/13 at 10:05 AM, the DON was asked what is expected from all staff when serving meal trays. The DON stated, &quot;...would expect staff to wash hands prior to serving and setting up trays...&quot; The DON confirmed that staff should not touch food and items with bare hands, and hand hygiene should be performed after touching residents or handling items.</td>
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<td>2. Review of the facility's &quot;Use of... Hairnets&quot; policy documented, &quot;...PURPOSE: To prevent the spread of bacteria that may cause food borne illnesses... &quot;PROCESS... i....Wear hair restraints (bonnets, caps, nets, to cover hair) when preparing or handling food...&quot;</td>
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<td>Observations in the kitchen on 11/14/13 at 11:42 AM, Maintenance Worker #1 walked into the kitchen without a hairnet and proceeded to obtain his tray from the trayline.</td>
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Continued From page 7

During an interview in the kitchen on 11/14/13 at 11:45 AM, the Certified Dietary Manager (CDM) was asked if the employees came into the kitchen without a hairnet to obtain their food. The CDM stated, "...They have been doing it for years..."