### Statement of Deficiencies and Plan of Correction

**NAME OF PROVIDER OR SUPPLIER:** BLEDSOE COUNTY NURSING HOME  
**STREET ADDRESS, CITY, STATE, ZIP CODE:** 107 WHEELERTOWN AVENUE  
PIKEVILLE, TN 37367

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<tr>
<th>ID PREFIX</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDERS PLAN OF CORRECTION</th>
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<tr>
<td>F 155</td>
<td>SS=D</td>
<td><strong>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</strong></td>
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The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, the facility failed to obtain advanced directive information for one resident (#8) of fifteen residents reviewed.

The findings included:

Resident #8 was admitted to the facility on June 22, 2009, and readmitted on March 25, 2010, with diagnoses including Chronic Obstructive Pulmonary Disease, Arteriosclerotic Cardiovascular Disease, Atrial Fibrillation and Chronic Pain.

Medical record review of the Minimum Data Set (MDS) dated July 11, 2010, revealed the resident was a DNR (Do Not Resuscitate) status. Medical record review of the MDS dated January 11, 2011, revealed the resident's Brief Interview for Mental Status (cognitive status) was one out of fifteen (fifteen being highest cognitive status).

Medical record review of the Social Services notes from admission to the present revealed no documentation of addressing advanced directive information with a responsible party.

Medical record review of the Patient Care Plan

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**LATERAL DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**  
**TITLE**  
**DATE**

Stephanie Bailey  
Administrator  
4/7/11

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**NOTE:** 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 enclosable 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 enclosable 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.

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**Event ID:** TG11H11  
**Facility ID:** TN4101  
**APR 04 2011**  
Continuation sheet Page 1 of 30

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4/11/11 - 4:05 p.m. Speaker AELM Related to additional info needed. Facility will send addendum to POC by 5:00 p.m. on Wed. 4/13/11. MaryAnn Dykew.
**BLED SOE COUNTY NURSING HOME**

**F 155 SS-D**

483.10(b)(4) **RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES**

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Medical record review of the Patient Care Plan

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**WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?**

All charts will be reviewed initially and during quarterly reviews or condition changes to identify the need for verification and updating of the POST by the Social Services Director and the MDS Coordinator.

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**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

---

**TITLE**

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**DATE**
**Bledsoe County Nursing Home**

**F 155**  
483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES

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Medical record review of the Patient Care Plan

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4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?

This will be monitored through chart reviews with the Social Services Director and the MDS Coordinator and through QA Committee for 6 months or as deemed necessary by the QA Committee.

QA Committee: Director of Nursing; MDS Coordinator; Dietary Supervisor; Social Services Director; Administrator, Pharmacist; Medical Director; Floor Nurse and C.N.A.

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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.
F 155 Continued From page 1 review dated October 13, 2009, January 13, 2010, March 25, 2010, and April 13, 2010, revealed the resident's "...Code status: DNR...or NO CPR..."

Interview, with the Social Worker on March 24, 2011, at 9:50 a.m. and 3:15 p.m., in the Social Worker's office, confirmed the social worker failed to obtain the Physician Orders for Scope of Treatment (POST) at admission. Further interview confirmed the social worker failed to periodically check the advanced directive status of the resident. Further interview revealed the responsible party was contacted and confirmed the DNR status was appropriate.

F 176 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE

An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, facility policy review, observation, and interview, the facility failed to assess one resident (#13) of fifteen residents reviewed for self-administration of medications.

The findings included:
 Resident #13 was admitted to the facility on January 4, 2011, with diagnoses including Hypertension and Hyperthyroidism.

Medical record review of the Minimum Data Set
Continued From page 2

(MDS) dated January 17, 2011, revealed the resident scored fourteen out of fifteen (fifteen being the highest cognitive status) on the Brief Interview for Mental Status (cognitive status).

Medical record review revealed no documentation the resident had been assessed for self-administration of medications.

Medical record review of the Physician's Recapitulation Orders dated March 2011, revealed, "...Self Administration of Meds...No..."

Review of the facility's "Resident Self-Administration of Drugs" policy revealed, "...If the resident expresses a desire to self-administer drugs, the attending physician will be notified. The interdisciplinary team, including the attending physician, will assess the resident to determine if this practice is safe..."

Observation and interview with the resident on March 22, 2011, at 10:35 a.m., revealed a thick, pink paste filled approximately 75 percent of a plastic 30 milliliter medicine cup, and was placed on top of a clear container of candy, on the resident's bedside table. The resident confirmed, "I put it (the paste) on my hemmorhoids...It's hemorrhoid cream...the nurse gave it to me (paste in medicine cup)..."

Interview with Licensed Practical Nurse (LPN) #1 on March 22, 2011, at 10:45 a.m., in the resident's room, confirmed the paste in the medicine cup was Calmoseptine Ointment (a moisture barrier that prevents and helps heal skin irritations). Continued interview confirmed the ointment did not belong in the resident's room and LPN #1 removed the ointment and discarded

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<td>HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</td>
<td>F 176</td>
<td>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</td>
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Residents were reviewed by the Director of Nurses to identify any potential residents who wishes to administer their own medications. All resident's rooms were visually searched by the C.N.A.'s and charge nurses on 3/22/11 for any other medications including creams.
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3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?

Any new residents who are admitted to the facility will be evaluated by the admitting nurse for the potential of administering their own medication using the form: "Evaluation for Self-Administration of Medications". This will begin 4/4/2011. Inservice was conducted 4/4/2011 by the Director of Nursing.

4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?

The Director of Nursing or the MDS Coordinator will review all new admit's charts to ensure forms are completed. This will be monitored by the QA committee for 6 months or until committee deems necessary.
F 176 Continued From page 3
it in the trash can on the medication cart.

Interview with the Director of Nursing (DON) and
MDS Coordinator at the nursing station on March
23, 2011, at 9:50 a.m., confirmed the facility failed
to assess the resident for self-administration of
medications.

F 221 483.13(a) RIGHT TO BE FREE FROM
PHYSICAL RERAINTS

The resident has the right to be free from any
physical restraints imposed for purposes of
discipline or convenience, and not required to
treat the resident's medical symptoms.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation,
and interview, the facility failed to complete the
pre-restraint assessment for one resident (#10);
failed to perform pre-restraint and quarterly
assessments for one resident (#11); and failed to
acquire consents for restraint use for three
residents (#9, #10, #11) of fifteen residents
reviewed.

The findings included:

Resident #9 was admitted to the facility on
September 1, 2006, with diagnoses including
Cerebral Palsy, Mental Retardation, and
Hypertension. Review of the Minimum Data Set
(MDS) dated March 3, 2011, revealed the
resident had short and long term memory
impairment, severe cognitive impairment,
required extensive assistance with transfers, was
non-ambulatory, and utilized a trunk restraint.

QA Committee: Director of Nursing; MDS Coordinator; Dietary
Supervisor; Social Services
Director; Administrator; Pharmacist;
Medical Director; Floor Nurse and
C.N.A.
Continued From page 4
Medical record review revealed no documentation the consent for restraint use had been obtained. Review of the Pre-Restraining Assessment dated September 1, 2008, revealed the resident had been evaluated for the use of a lap buddy, a soft, padded device positioned between the armrests of the wheelchair.

Observation on March 23, 2011, at 4:00 p.m., revealed the resident seated in the wheelchair with the lap buddy placed between the armrests of the wheelchair.

Interview with the Director of Nursing (DON) on March 23, 2011, at 4:30 p.m., in the DON's office confirmed the facility had not obtained the consent for restraint use for resident # 9.

Resident #10 was admitted to the facility on September 23, 2008, with diagnoses including Alzheimer's Dementia, Osteoarthritis, and Diabetes Mellitus. Review of the Minimum Data Set (MDS) dated January 6, 2011, revealed the resident required extensive assistance of two persons for transfers, was non-ambulatory, and had bilateral limited range of motion of the lower extremities. Continued review of the same MDS revealed the resident used a chair that prevented rising.

Medical record review revealed no documentation the facility had obtained consent for restraint use for resident #10.

Observation on March 24, 2011, at 9:30 a.m., revealed the resident in a geri-chair, slightly reclined with a table top tray across the arms on the chair. Continued observation revealed the resident's hands and forearms were resting on

F 221

1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?

Resident #9: Restraint consent will be obtained for the use of "lap buddy" by 4/30/11

Resident #10: Restraint consent was obtained for the use of Geri-chair. A new "Pre-restraining Assessment was performed by the charge nurse on 4/4/11.

Resident #11: A new "Pre-restraining Assessment was completed by the charge nurse on 4/4/2011. The Pummal Cushion was removed as a "restraint" and documented as "an enabler" (as residents is unable to get out of wheelchair by himself even without the cushion in place) by the MDS Coordinator on the MDS as well as the C.N.A. worksheets.
| F 221 | Continued From page 5 the table top. Review of the Pre-Restraining Assessment for resident #10 revealed the resident had balance problems and had been assessed as "falls/leans sideways to the left and to the right." Continued review of the Pre-Restraining Assessment revealed the interdisciplinary team evaluation had not been completed, signed, and dated by the facility representative. Interview with the MDS Coordinator on March 24, 2011, at 11:30 a.m., in the MDS Coordinator's office confirmed the Pre-Restraining Assessment was incomplete. Interview with the Director of Nursing (DON) on March 23, 2011, at 4:30 p.m., in the DON's office confirmed the facility had not obtained the consent for restraint use for resident #10. Resident #11 was admitted to the facility on June 4, 2010, with diagnoses including Post Cardiovascular Accident (Stroke), Hypertension, and Dementia. Medical record review of the Physician's Recapitulation Orders dated March 2011, revealed "...Wedge cushion when up in wheelchair..." Medical record review of the resident's current care plan revealed, "...Problem: Resident requires use of wedge cushion when up in wheelchair for safety and due to leans and inability to rebalance self...Goal: Resident's use of the cushion will be eliminated...Approach: Use least restrictive type of restraint particle (practical) may remove restraint when under 2) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE? The 802 was reviewed by the Director of Nursing on 3/31/11 and updated to correct identify the use of "restraints" on residents. Charts will be reviewed by the Director of Nursing for evidence of the "Pre-Restraining Assessment." This will be accomplished by 4/30/11. 3) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? An inservice was conducted 4/4/2011 by the Director of Nursing. The MDS Coordinator will re-assess each resident requiring restraints quarterly for potential of reduction and/or elimination. Restraint Consents will be obtained on all residents identified as requiring restraints by 4/30/11.
### Summary Statement of Deficiencies

**F 221** Continued From page 6
direct supervision by staff or family...reassess need for restraints at least quarterly and prn (as needed)...assess & (and) explore alternatives; document findings; obtain order and/or permission to implement...

Medical record review of the resident's "Pre-Restraining Assessment" revealed the assessment was blank (not completed).

Medical record review revealed no signed consent for the use of the wedge cushion.

Medical record review revealed no documentation of reassessment of the restraint for reduction and/or elimination.

Observation on March 23, 2011, at 4:00 p.m., in the dining room, revealed the resident sitting in a wheelchair with a wedge foam pommel cushion in the seat of the wheelchair.

Interview with the Director of Nursing (DON) on March 23, 2011, at 4:15 p.m., at the nursing station, confirmed the facility failed to complete a pre-restraint assessment for the least restrictive intervention; failed to obtain consent to use the restraint; and failed to re-assess the restraint for reduction and/or elimination at least quarterly and prn for the resident.

**F 309**

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.

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<td>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</td>
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The Director of Nursing or the MDS Coordinator will review the chart of any resident who requires the use of a restraint for the signed "Restraint Consent".
The Director of Nursing will monitor for completion of "Restraint Reduction/Elimination" form.
This will be monitored by the QA Committee for 6 months or as deemed necessary by the QA Committee.

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*Note: The handwriting on the form includes some corrections and annotations.*
This REQUIREMENT is not met as evidenced by:
Based on medical record review, facility document review, policy review, and interview, the facility failed to assess for pain for one resident (#5) of fifteen residents reviewed.

The findings included:

Resident #5 was admitted to the facility on May 14, 2010, with diagnoses including Osteoarthritis, Congestive Heart Failure and Chronic Pain Syndrome.

Medical record review of the Minimum Data Set (MDS) dated February 24, 2011, revealed the resident received scheduled and as needed pain medication. Further review revealed the pain was experienced frequently with an intensity of eight out of ten (ten being the worst pain imaginable) and a verbal description of "...very severe, horrible..."

Medical record review of the "Initial Pain Assessment Tool" dated May 14, 2010, revealed "...Location of the pain: (no) c/o (complaints) of pain at this time. Hx: neck, bil (bilateral) leg, back, bil shoulder...Intensity: (0-10 scale) not present, worse pain gets 8...What relieves pain: "pain pill I get 3 times a day"...Plan: Hydrocodone-APAP 5/500 one po TID (by mouth three times daily)"

Medical record review of the physician order initiated on May 14, 2010, to the present date, revealed "...Hydrocodone (pain

1. WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?

Medications for Resident #5 were reviewed by the Physician on 3/30/11. Resident’s medications were changed from PRN to routine on that day. Resident #5 was assessed using "Pain Assessment Monitor" form by the Charge Nurse on 4/4/2011.

2. HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?

All resident’s MARs and Medications were reviewed and discussed by the Charge Nurses and Director of Nursing on 4/4/2011.
Continued From page 8 medication)...5/500 take one tablet every 8 hours as needed (PRN) for pain..."

Medical record review of the Medication Administration Record (MAR) for February 2011, revealed daily PRN Hydrocodone administrations documented except for February 1, 4, and 15. Further review the PRN Hydrocodone administration times documented revealed one administration at 7:00 a.m.; ten administrations between 8:00 and 9:00 a.m.; one administration at 10:00 a.m.; one administration at 6:00 p.m.; seventeen administrations between 7:30 and 8:00 p.m.; and one administration at 9:00 p.m.

Medical record review of the MAR for March 1-23, 2011, revealed daily PRN Hydrocodone administrations documented. Further review the PRN Hydrocodone administration times documented revealed one each administration at 3:00 a.m., 6:00 a.m., 7:00 a.m.; twelve administrations between 8:00 and 9:00 a.m.; one administration at 10:00 a.m.; one administration at 2:30 p.m.; eleven administrations between 7:30 and 8:00 p.m.; and one administration at 10:15 p.m.

Medical record review of the care plan initiated June 2, 2010, to the present date, revealed the "...resident voices repetitive health complaints...Goal: resident's repetitive expressions of concern regarding health problems: has daily complaints of pain R/T (related to) Osteoarthritis...Approaches: 1) Assess factual basis for complaint attempt to resolve and/or alleviate any related discomfort...8) Administer Hydrocodone 5/500 3 times a day as needed for pain..."
STATEMENT OF DEFICIENCIES 
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
BLEDSOE COUNTY NURSING HOME

SUMMARY STATEMENT OF DEFICIENCIES 
(EACH DEFICIENCY MUST BE PRECEDED BY 
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ID PREFIX TAG
F 309

Continued From page 9
Review of the facility policy for "Pain Assessment" revealed the "$...Purpose: To correctly assess a resident's level of pain and provide appropriate intervention to control/prevent pain...Procedure: Upon admission, each resident will be assessed for complaints of pain by the ADON (Assistant Director of Nursing) or the charge nurse. The results will be placed in the resident's medical record. The cause and methods of pain control will be documented in the care plan...
"

Review of the facility policy for "Physician Notification of Change in Resident Status Policy" revealed the "$...Purpose: To establish guidelines to inform the nurse when a physician must be notified...Procedure: The physician will be notified of the following unless otherwise ordered: 2. A physician will be notified when a doctor's order needs clarification...14. Any other circumstances as indicated by resident's behavior, condition or status warrants (warrants)..."

Interview, with Licensed Practical Nurse (LPN) #3, on March 24, 2011, at 8:00 a.m., in the hall by room 126, confirmed the Medication Administration Record Nurse's Medication Notes for December 2010 through March 2011, did not document the level of pain at the time of the administration of the medication or as part of the effectiveness. Further interview confirmed there was no documentation the pain level was assessed. Further interview confirmed the physician had not been notified of the daily administration of the PRN Hydrocodone in February and March 2011, due to the "$...different times of the administration and no pattern established...."

F 309

4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?

The Director of Nursing or the MDS Coordinator will review all new admissions and hospital returns for completed forms. This will be monitored by the QA Committee for 6 months or as deemed necessary by the QA Committee.

QA Committee: Director of Nursing; MDS Coordinator; Dietary Supervisor; Social Services Director; Administrator; Pharmacist; Medical Director; Floor Nurse and C.N.A.

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<td>Interview, with the Director of Nursing (DON) in the chapel on March 24, 2011, at 8:27 a.m., confirmed the facility assessed pain only at admission and not at readmission. Further interview confirmed there was no ongoing assessment or tracking of pain. Further interview confirmed the physician had not been notified regarding the daily Hydrocodone administration in February and March 2011. Further interview revealed the MDS Coordinator assessed the pain as part of the MDS review.</td>
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<td>F 315</td>
<td>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</td>
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<td>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.</td>
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<td>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</td>
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<td>Resident #1 was assessed for the need of a foley catheter upon hospital return on 3/30/11 by the admitting nurse.</td>
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<td>Resident #6 has had her foley discontinued on 11/10/2010.</td>
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F 315
**F 315** Continued From page 11

by:

Based on medical record review, observation, and interview, the facility failed to provide medical justification and assessment for indwelling catheter usage for two residents (#1, #6) of fifteen residents reviewed.

The findings included:

Resident #1 was admitted to the facility on July 7, 2010, with diagnoses including Alzheimer's Disease, Chronic Obstructive Pulmonary Disease, Hypertension, and Tremors. Resident #1 was readmitted to the facility on March 3, 2011, with diagnoses including Urinary Tract Infection and Dehydration.

Review of the Minimum Data Set (MDS) dated January 20, 2011, revealed the resident had significant cognitive impairment, required extensive assistance for transfers, was non-ambulatory, and was incontinent of bladder.

Review of the Physician's Order dated March 3, 2011, revealed, "Foley care q (every) shift & (and) prn (as needed) Foley catheter cont (continued) from hospital."

Medical record review revealed no assessment to determine the medical justification for continued use of the indwelling catheter. Review of the resident's care plan dated January 20, 2011, revealed the care plan had not been revised to include the resident's use of the indwelling catheter, and interventions related to caring for the indwelling catheter.

Interview with the MDS Coordinator on March 24, 2011, at 8:30 a.m., in the Coordinator's office

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**2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?**

All residents were reviewed by the Director of Nursing and the 7-3 Charge Nurse on 4/4/11. Resident(s) requiring a foley catheter was assessed using the "...Inwelling Catheter Evaluation" form by the 7-3 Charge Nurses on 4/4/2011.
Continued From page 12
confirmed the resident had not been assessed for medical justification for the use of the indwelling catheter, and the care plan had not been revised to reflect the use of the indwelling catheter.

Resident #6 was admitted to the facility on June 29, 2009, with diagnoses including Paralysis, Ruptured Cerebral Aneurysm, Cerebrovascular Accident with Right Hemiparesis, and Insulin Dependent Diabetes Mellitus.


Medical record review of the Assessment for Bowel and Bladder Training dated June 29, 2010, revealed "...present bladder: Foley...Evaluation: ...Unable to participate in B/B (Bowel/Bladder) training-Reason: sp (status post) CVA (Cerebrovascular Accident) with Right side paralysis..."

Medical record review of the Progress Notes dated October 12, 2010, revealed "...Indwelling cath. (catheter) cont. (continued), trtr (treated) for several U.T.I. (Urinary Tract Infections)...Not a candidate for training...signed by the Minimum Data Set Coordinator..."

Interview, with the Director of Nursing (DON) on March 23, 2011, at 9:15 a.m., and March 24, 2011, at 2:35 p.m., in the DON’s office, confirmed the facility did not perform an admission catheter assessment to determine appropriateness of

WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?

In-service was conducted on 4/4/2011 by the Director of Nursing. “Urinary Incontinence/Indwelling Catheter Evaluation” will be performed by the admitting nurse on all residents who are admitted or re-admitted with a foley catheter. The Physician’s were informed by the Director of Nursing on 4/4/2011 of the need for a diagnosis/medical justification for the use of a foley catheter. Nursing Staff will use the “Lippencott” book of “Standards of Nursing Practice” to determine appropriate use of foley catheter.
## Continued From page 12

confirmed the resident had not been assessed for medical justification for the use of the indwelling catheter, and the care plan had not been revised to reflect the use of the indwelling catheter.

Resident #6 was admitted to the facility on June 29, 2009, with diagnoses including Paralysis, Ruptured Cerebral Aneurysm, Cerebrovascular Accident with Right Hemiparesis, and Insulin Dependent Diabetes Mellitus.


Medical record review of the Assessment for Bowel and Bladder Training dated June 29, 2010, revealed "...present bladder: Foley...Evaluation: Unable to participate in B/B (Bowel/Bladder) training-Reason: sp (status post) CVA (Cerebrovascular Accident) with Right side paralysis...".

Medical record review of the Progress Notes dated October 12, 2010, revealed "...Indwelling cath. (catheter) cont. (continued), tried (treated) for several U.T.I. (Urinary Tract Infections)...Not a candidate for training...signed by the Minimum Data Set Coordinator..."

Interview, with the Director of Nursing (DON) on March 23, 2011, at 9:15 a.m., and March 24, 2011, at 2:35 p.m., in the DON's office, confirmed the facility did not perform an admission catheter assessment to determine appropriateness of

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### 4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?

The Director of Nursing or the MDS Coordinator will review all new admissions or re-admissions with a foley catheter for appropriate forms and diagnosis. This will be monitored by the QA Committee for 6 months or as deemed necessary by the committee.

QA Committee: Director of Nursing; MDS Coordinator; Dietary Supervisor; Social Services Director; Administrator; Pharmacist; Medical Director; Floor Nurse and C.N.A.
<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFiciencies</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 315</td>
<td>Continued From page 13 need. Further interview confirmed there was no ongoing assessment to determine appropriateness of need for the catheter. Further interview confirmed the facility had no policy for catheter use.</td>
<td>F 315</td>
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<tr>
<td>F 322</td>
<td>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</td>
<td>F 322</td>
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<td>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a nasogastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasopharyngeal ulcers and to restore, if possible, normal eating skills.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on medical record review, policy review, and staff interview, the facility failed to provide the tube feeding formula as ordered by the physician, failed to clarify the physician order for the tube feeding, failed to notify the physician the tube feed formula ordered was not available, and administered a formula not ordered by the physician for one resident (#8) of fifteen residents reviewed.</td>
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<td>The findings included: Resident #8 was admitted to the facility on June 22, 2009, with diagnoses including Chronic Obstructive Pulmonary Disease, Arteriosclerotic Cardiovascular Disease, Atrial Fibrillation, Percutaneous Endoscopic Gastrostomy, and Chronic Pain.</td>
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Continued From page 14

Medical record review of the Minimum Data Set (MDS) dated January 12, 2011, revealed the resident's Brief Interview for Mental Status (cognitive status) was 1 out of fifteen (fifteen being highest cognitive status); fed by tube feeding greater than 501 cubic centimeters per day; and received greater than fifty-one percent of calories by the tube feeding.

Medical record review of the Recapitulation physician orders dated December 2010, through March 2011, revealed the following tube feeding orders originated at admission:

A.) "PEG Tube: 1 Cal (calorie) HN (High Nitrogen) 237 ml (milliliters) at bedtime follow with 250 ml water..."

B.) "Peg Tube: 2 Cal HN 237 ml follow with 237 ml (of) water..."

Medical record review of the December 2010, through March 2011, Recapitulation physician orders, originating on March 31, 2010, revealed "feeding tube 118 ml at 9 am and 3 p.m. flush with 100 ml water after each..."

Medical record review of the Weight Record revealed the resident's weight was stable at 119-128 pounds from May 2010 through February 2011.

Review of the facility policy for "Physician Notification of Change in Resident Status Policy" revealed the "...Purpose: To establish guidelines to inform the nurse when a physician must be notified...Procedure: The physician will be notified of the following unless otherwise ordered:

2. A physician will be notified when a doctor's order needs clarification...14. Any other circumstances as indicated by resident's...

2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?

All residents who require tube feedings were reviewed by the Director of Nursing on 3/30/11 for clear orders.

3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?

In-service was conducted on 4/4/2011 by the Director of Nursing. The Policy "Physician notification of Change" was reviewed with emphasis on notifying the physician when orders need clarifying. The DON will review policy with nurses on LOA upon their return to work, also with nurses who missed the in-service by 4/30/11.
### SUMMARY STATEMENT OF DEFICIENCIES

#### F 322

Continued From page 15 behavior, condition or status warrents..."

Interview, with the Director of Nursing (DON) on March 24, 2011, at 10:12 a.m., in the DON's office and medicine room, revealed that the DON thought the resident was provided 1.0 Cal Glucerna for the 1 Cal HN 237 ml at bedtime due to the resident being a diabetic. The DON confirmed 1.0 Cal Glucerna was provided to the resident at bedtime.

Interview, by phone, with Licensed Practical Nurse (LPN) #5, on March 24, 2011, at 10:15 a.m., confirmed the LPN administered 1.0 Cal Glucerna at bedtime. Further interview revealed the LPN "...gives whatever the MAR says..." Further interview with LPN #5, at 12:40 p.m., at the nursing station, on March 24, 2011, confirmed the LPN administered 1.0 Cal Glucerna at bedtime.

Interview, by phone, with LPN #4, on March 24, 2011, at 10:41 a.m., confirmed the LPN administered 2 Cal HN at bedtime.

Interview, by phone, with LPN #1 on March 24, 2011, at 12:50 p.m., confirmed the LPN administered 1.0 Cal Glucerna at bedtime. Further interview revealed the LPN was aware there was no product such as 1 Cal HN from working at the hospital. Further interview confirmed LPN #1 had not notified the physician there was no product called 1 Cal HN. Further interview revealed "...a day shift nurse told me to use Glucerna..."

Interview, by phone, with LPN #6, on March 24, 2011, at 12:53 p.m., revealed the LPN administered 1.0 Cal Glucerna at bedtime.

### PROVIDER'S PLAN OF CORRECTION

#### F 322

4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?

MARs will be checked by 2 charge nurses monthly and as needed with new orders for clarification. New orders will be checked by at least 1 nurse on each shift for correctness and clarification as evidenced by the nurse’s initials on the "yellow" copy of the order sheet. The DON will them check for initials as well as correct and clear documentation. This will be monitored by the QA Committee for 6 months or as deemed necessary by the committee.

QA Committee: Director of Nursing; MDS Coordinator; Dietary Supervisor; Social Services Director; Administrator; Pharmacist; Medical Director; Floor Nurse and C.N.A.
Continued From page 16
because the "...can says 1.0 Cal..." Further
Interview confirmed the LPN did not notify the
physician that 1 Cal HN was not available.

Interview, by phone, with the facility Registered
Dietitian (RD) on March 24, 2011, at 1:32 p.m.,
confirmed the RD thought all formula provided
was 2 Cal HN. When read the 1 Cal HN at
bedtime order the RD revealed the RD was not
aware of such an order and there was no such
product as 1 Cal HN. Further interview revealed
the RD was not aware the nurses were
administering 1.0 Cal Glucerna at bedtime.

Interview, with LPN #3, on March 24, 2011, at
10:50 a.m., in the hall by the resident’s room,
revealed this LPN administered 2 Cal HN at 10:00
a.m. When read the 118 ml order and asked how
did the LPN know what formula to administer the
LPN revealed "...because the 2 Cal HN 237 ml
order is written above the 118 ml order..."

Interview with the facility Material Director, on
March 24, 2011, at 1:40 p.m., in the
Administrative Office, revealed "...would order
what nursing tells me based on physician order...would notify any nurse that product not
available..."

Interview, in the Chapel, with the DON on March
24, 2011, at 12:57 p.m., confirmed the DON was
not aware there was no such product as 1 Cal
HN. Further interview confirmed the 2 Cal HN
order did not specify the frequency of the
administration. Further interview confirmed the
order of 118 ml at 9:00 a.m. and 3:00 p.m. did not
specify a formula to be administered. Further
interview confirmed the facility failed to notify the
physician that there was no such product as 1 Cal
1. WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?

Resident #15: All personal hygiene products were properly stored out of residents view. Used razors were placed in sharps container by the C.N.A.’s on duty for B Hall on 3/22/11. Open razors and other items were placed in the secure cabinet between showers by the C.N.A.s beginning on 3/22/11.

Resident #1: The bed alarm was attach to the resident properly by the Director of Nursing on 3/22/11.
<table>
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<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F 323</td>
<td>Continued From page 18</td>
<td>Observation during the initial tour on March 22, 2011, at 11:00 a.m., revealed the following items on the resident's over bed table: Baby Oil, 20 ounces, ¾ full; Mouthwash containing 26.9 % alcohol, 50 ounces, ¾ full; Petroleum jelly, 3.75 ounces, minimal contents remaining. Continued observation at this time in the resident's bathroom revealed two disposable razors on the back of the resident's sink. Observation and interview with LPN #1, on March 22, 2011, at 11:15 a.m., confirmed the razors should not have been left on the back of the sink. Observation and interview with the Director of Nursing (DON) on March 22, 2011, at 11:30 a.m., in the resident's room confirmed the items found on the resident's over bed table belonged to the resident, and had not been stored in a secure manner. Continued observation and interview with the DON confirmed the razors should have been placed in a sharps container. Observation of the resident-accessible, B-hall shower room on March 23, 2011, at 9:15 a.m., revealed an open package of disposable razors stored on the linen cart. Observation and interview with the DON on March 23, 2011, at 11:30 a.m., in the B-hall shower room confirmed the razors had not been stored in a safe, secure manner. Resident #1 was admitted to the facility on July 7, 2010, with diagnoses including Alzheimer's Dementia, Chronic Obstructive Pulmonary</td>
<td>F 323</td>
<td>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</td>
<td>April 4, 2011</td>
</tr>
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</table>

A visual inspection of all resident rooms and shower rooms was conducted by the Director of Nursing, the Administrator and various members of the Nursing Staff on 3/22/11, 3/23/11 and 3/24/11 to ensure proper placement of sharps and "chemicals". Each resident who required a personal alarm was inspected by the Director of Nursing on 3/22/11 for proper placement.
Continued From page 18
Observation during the initial tour on March 22, 2011, at 11:00 a.m., revealed the following items on the resident’s over bed table: Baby Oil, 20 ounces, ¾ full; Mouthwash containing 26.9% alcohol, 50 ounces, ¾ full; Petroleum jelly, 3.75 ounces, minimal contents remaining.

Continued observation at this time in the resident’s bathroom revealed two disposable razors on the back of the resident’s sink.

Observation and interview with LPN #1, on March 22, 2011, at 11:15 a.m., confirmed the razors should not have been left on the back of the sink.

Observation and interview with the Director of Nursing (DON) on March 22, 2011, at 11:30 a.m., in the resident’s room confirmed the items found on the resident’s over bed table belonged to the resident, and had not been stored in a secure manner.

Continued observation and interview with the DON confirmed the razors should have been placed in a sharps container.

Observation of the resident-accessible, B-hall shower room on March 23, 2011, at 9:15 a.m., revealed an open package of disposable razors stored on the linen cart.

Observation and interview with the DON on March 23, 2011, at 11:30 a.m., in the B-hall shower room confirmed the razors had not been stored in a safe, secure manner.

Resident #1 was admitted to the facility on July 7, 2010, with diagnoses including Alzheimer’s Dementia, Chronic Obstructive Pulmonary

3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?

Inservice was conducted on 4/4/11 by the Director of Nursing. Charge Nurses on each shift will monitor residents for proper alarm placement during medication pass times. (This will be on-going). Charge Nurses will conduct visual inspections of the resident’s rooms during medication passes to ensure proper placement of personal hygiene and “chemicals”. (This will be on-going).
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
BLEDSOE COUNTY NURSING HOME

**STREET ADDRESS, CITY, STATE, ZIP CODE**
107 WHELEERTOWN AVENUE
PIKEVILLE, TN 37367

**ID PREFIX TAG**

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<td>F</td>
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**SUMMARY STATEMENT OF DEFICIENCIES**
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION)

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<thead>
<tr>
<th>F 323</th>
<th>Continued From page 19</th>
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<tbody>
<tr>
<td>Disease, History of Falls, and Tremors. Review of the Minimum Data Set (MDS) dated January 20, 2011, revealed the resident had significant cognitive impairment, required extensive assistance for transfers, was non-ambulatory, and incontinent of bladder.</td>
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</table>

Review of the facility's documentation revealed the resident was a high risk for falls, and had care plan interventions dated January 20, 2011, for the use of a bed/chair alarm at all times. Review of the Physician's Orders dated March 20, 2011, revealed, "Bed Alarm when in bed."

Observation during the initial tour on March 22, 2011, at 10:45 a.m., and March 23, 2011, at 10:30 a.m., revealed the resident in bed, side rails up, and a tab alarm on the right side rail, unattached to the resident.

Observation and interview with the Director of Nursing on March 23, 2011, at 10:30 a.m., in the resident's room confirmed the tab alarm was not attached to the resident.

**F 425**

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

The facility must provide routine and emergency 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

**F 323**

4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?

Inservice by the Director of Nursing on 4/4/2011. Monitored daily by the Charge Nurses on each shift. Random monitoring by the DON and/or the MDS Coordinator. Will be monitored by the QA Committee for 6 months or as deemed necessary by the committee.

QA Committee: Director of Nursing; MDS Coordinator; Dietary Supervisor; Social Services Director; Administrator; Pharmacist; Medical Director; Floor Nurse and C.N.A.
**F 425** Continued From page 20

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 observation, review of the facility's consultant pharmacist report, and interview, the facility failed to ensure the pharmacist provided the timely identification and removal (from current medication supply) of expired medications for disposition.

The findings included:


Observation of the medication room on March 23, 2011, at 9:00 a.m., revealed the following expired medications in the Emergency Medications Box: Digoxin Injection-500mcg/2ml vial (500 micrograms per 2 milliliters); one vial with a manufacturer's expiration date of March 2007 on the label of the vial;

Atropine Sulfate Injection-1mg (milligram); two vials with a manufacturer's expiration date of March 1, 2007 on the label of the vials;

Atropine Sulfate Injection-1mg (milligram); one vial with a manufacturer's expiration date of July

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<tr>
<th>ID PREFIX TAG</th>
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<tbody>
<tr>
<td>F 425</td>
<td>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</td>
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<tr>
<td></td>
<td>All expired medications were removed from the medication room and disposed of on March 23, 2011.</td>
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2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?

The medication room was checked by the Director of Nursing and the 7-3 Charge Nurse on 3/23/11 to ensure no expired medications remained.
Continued From page 21
1, 2007 on the label of the vial;
50% (percent) Dextrose Injection-25gms (grams); one vial with a manufacturer's expiration date of August 1, 2007 on the label of the vial;
Bacteriostatic 0.9% Sodium Chloride Injection-30ml Multiple-Dose vial; two vials with a manufacturer's expiration date of September 1, 2007 on the label of the vials;
Epinephrine Injection-1mg/ml vial (one milligram per milliliter); one vial with a manufacturer's expiration date of April 1, 2008 on the label of the vial;
Digoxin Injection-500mcg/2ml vial (500 micrograms per 2 milliliters); one vial with a manufacturer's expiration date of December 2008 on the label vial.

Continued observation in a cabinet attached to the wall inside the medication room revealed multiple cartons of medications with the manufacturer's expiration date of January 2011 on the cartons as follows:
Five cartons of Ipratropium Bromide 0.5mg and Albuterol Sulfate 3mg Inhalation Solution, for a total of 165 expired unit-dose vials;
Four carton of Ipratropium Bromide 0.5mg/2.5ml Inhalation Solution, for a total of 240 expired unit-dose vials.

Interview with the consultant pharmacist via telephone from the facility conference room on March 23, 2011, at 1:00 p.m., confirmed the consultant pharmacist's monthly reports for December 2010, and January and February 2011 were inaccurate. Further interview confirmed the facility no longer used the Emergency Medications Box as emergency situations are handled in the hospital emergency room (located in the same building beside the nursing home).

3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?

The Consultant Pharmacist will make visual inspections of the medication room at least monthly.
Inservice was conducted 4/4/2011 by the Director of Nursing.
The 3-11 Charge Nurse will be responsible for inspecting the medication room weekly to ensure no medications are expired.
The Charge Nurse will document her findings. The Director of Nursing or the MDS Coordinator will make weekly checks of documentation.
The Emergency Box was discussed with the Medical Director by the Director of Nursing and it has been decided not to have the current Emergency box in place due to the close proximity of Emergency Room (the hospital is attached to the nursing home)
Continued From page 21

1. 2007 on the label of the vial;
50% (percent) Dextrose Injection-25gms (grams);
one vial with a manufacturer's expiration date of
August 1, 2007 on the label of the vial;
Bacteriostatic 0.9% Sodium Chloride
Injection-30ml Multiple-Dose vial; two vials with a
manufacturer's expiration date of September 1,
2007 on the label of the vials;
Epinephrine Injection-1mg/ml vial (one milligram
per milliliter); one vial with a manufacturer's
expiration date of April 1, 2008 on the label of the
vial;
Digoxin Injection-500mcg/2ml vial (500
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telephone from the facility conference room on
March 23, 2011, at 1:00 p.m., confirmed the
consultant pharmacist's monthly reports for
December 2010, and January and February 2011
were inaccurate. Further interview confirmed the
facility no longer used the Emergency
Medications Box as emergency situations are
handled in the hospital emergency room (located
in the same building beside the nursing home).

4.) HOW THE CORRECTIVE
ACTION(S) WILL BE
MONITORED TO ENSURE
THE DEFICIENT PRACTICE
WILL NOT RECUR?

The Director of Nursing or the MDS
Coordinator will make weekly
checks of documentation.
This will be monitored by the QA
Committee for 6 months or as
deemed necessary by the
Committee.

QA Committee: Director of
Nursing; MDS Coordinator; Dietary
Supervisor; Social Services
Director; Administrator; Pharmacist;
Medical Director; Floor Nurse and
C.N.A.
**NAME OF PROVIDER OR SUPPLIER**

**BLEDSOE COUNTY NURSING HOME**

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<th>ID</th>
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<th>(X5) COMPLETION DATE</th>
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<tr>
<td>F 425</td>
<td>Continued From page 22 Continued interview confirmed the consultant pharmacist failed to ensure the timely identification and removal of expired medications from the facility's current medication supply in the medication room.</td>
<td>F 425</td>
<td>431</td>
<td>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE? All expired medications were removed from the medication room and disposed of on March 23, 2011.</td>
<td>4/4/11</td>
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<tr>
<td>F 431</td>
<td>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be 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.</td>
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This REQUIREMENT is not met as evidenced by:

Based on observation and interview, the facility failed to ensure the disposal of expired medications from the medication room.

The findings included:

Observation on March 23, 2011, at 9:00 a.m., of the medication room, revealed the following expired medications in the Emergency Medications Box:
- Digoxin Injection-500mcg/2ml vial (500 micrograms per 2 milliliters); one vial with a manufacturer's expiration date of March 2007 on the label of the vial;
- Atropine Sulfate Injection-1mg (milligram); two vials with a manufacturer's expiration date of March 1, 2007 on the label of the vials;
- Atropine Sulfate Injection-1mg (milligram); one vial with a manufacturer's expiration date of July 1, 2007 on the label of the vial;
- 50% (percent) Dextrose Injection-25gms (grams); one vial with a manufacturer's expiration date of August 1, 2007 on the label of the vial;
- Bacteriostatic 0.9% Sodium Chloride Injection-30ml Multiple-Dose vial; two vials with a manufacturer's expiration date of September 1, 2007 on the label of the vials;
- Epinephrine Injection-1mg/ml vial (one milligram per milliliter); one vial with a manufacturer's expiration date of April 1, 2008 on the label of the vial;
- Digoxin Injection-500mcg/2ml vial (500 micrograms per 2 milliliters); one vial with a manufacturer's expiration date of December 2008.
F 431 Continued From page 24 on the label vial;

Continued observation in a cabinet attached to the wall inside the medication room revealed multiple cartons of medications with the manufacturer’s expiration date of January 2011 on the cartons as follows:
Five cartons of Ipratropium Bromide 0.5mg and Albuterol Sulfate 3mg Inhalation Solution, for a total of 165 expired unit-dose vials;
Four carton of Ipratropium Bromide 0.5mg/2.5ml Inhalation Solution, for a total of 240 expired unit-dose vials.

Interview with Licensed Practical Nurse (LPN) #2 in medication room on March 23, 2011, at 9:30 a.m., confirmed the facility failed to dispose of the expired medications from the medication room.

F 502 SS=D 483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, review of laboratory data, review of treatment sheets, and interview, the facility failed to obtain a Vitamin D level as ordered by the physician for one resident (#8) of fifteen residents reviewed.

The findings included:

Resident #8 was admitted to the facility on June 22, 2009, with diagnoses including Chronic

4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?

The Director of Nursing or the MDS Coordinator will make weekly checks of documentation.
This will be monitored by the QA Committee for 6 months or as deemed necessary by the Committee.

QA Committee: Director of Nursing; MDS Coordinator; Dietary Supervisor; Social Services Director; Administrator; Pharmacist; Medical Director; Floor Nurse and C.N.A.

1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?

Resident #8: Lab requisition was sent to the laboratory for level to be drawn on 3/24/11.
**NAME OF PROVIDER OR SUPPLIER**

**BLEDSOE COUNTY NURSING HOME**

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

107 WHEELERTOWN AVENUE
PIKEVILLE, TN 37367

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<table>
<thead>
<tr>
<th>(X4) ID PREFIX</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 502</td>
<td>Continued From page 25 Obstructive Pulmonary Disease, Arteriosclerotic Cardiovascular Disease, Atrial Fibrillation and Chronic Pain. Medical record review of a physician phone order dated January 6, 2011, revealed &quot;...2) Vit. (Vitamin) D level in early March...&quot; Medical record review of the laboratory data revealed no documentation of a Vitamin D level for March 2011. Medical record review of the February and March 2011, treatment sheets revealed no documentation to obtain a Vitamin D level in March 2011. Interview, with the Director of Nursing on March 24, 2011, at 10:37 a.m., in the DON's office, confirmed the facility failed to obtain the Vitamin D level as ordered by the physician. Further interview revealed the facility wrote the order on the treatment sheet for January 2011, and were to carry it forward on the February and March 2011, treatment sheets until the order was obtained.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(X5) COMPLETION DATE</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/31/11</td>
<td>HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</td>
</tr>
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</table>

January, February and March treatment sheets were reviewed for all residents by the Director of Nursing 3/29, 30 & 31/2011 for appropriate documentation and "carry-over".

<table>
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<tr>
<th>F 514</th>
<th>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</th>
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</thead>
</table>

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.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and

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If continuation sheet Page 26 of 30

**APR 8 2011**
BLEDSE0 COUNTY NURSING HOME

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CQA IDENTIFICATION NUMBER: 44E232

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
03/24/2011

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE
167 WHEELERTOWN AVENUE
PIKEVILLE, TN 37367

(X4) ID PREFIX TAG

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

ID PREFIX TAG

F 502

(4) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR.

The Director of Nursing will check the treatment sheets weekly for accurate orders.

Any new orders will be checked by at least one nurse from each shift and indicate correctness by initials on a copy of the order.

This will be monitored by the QA committee for 6 months or until deemed by the committee.

Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)

F 502

Interview, with the Director of Nursing on March 24, 2011, at 10:37 a.m., in the DON's office, confirmed the facility failed to obtain the Vitamin D level as ordered by the physician. Further interview revealed the facility wrote the order on the treatment sheet for January 2011, and were to carry it forward on the February and March 2011, treatment sheets until the order was obtained.

483.75(1)(1) RES

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.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and

F 514

SS=D RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

QA Committee: Director of Nursing; MDS Coordinator; Dietary Supervisor; Social Services Director; Administrator; Pharmacist; Medical Director; Floor Nurse and C.N.A.
F 514 Continued From page 26
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, pharmacy
consultant document review, and interview, the
facility failed to maintain an accurate medical
record for one resident (#5) of fifteen residents
reviewed.

The findings included:

Resident #5 was admitted to the facility on May
14, 2010, with diagnoses including Osteoarthritis,
Congestive Heart Failure and Chronic Pain Syndrome.

Medical record review of the Minimum Data Set
dated February 24, 2011, revealed the resident
received scheduled and as needed pain
medication. Further review revealed the pain was
experienced frequently with an intensity of eight
out of ten (ten being the worst pain imaginable)
and a verbal description of "...very severe,
horrible..."

Medical record review revealed an "Initial Pain
Assessment Tool" dated May 14, 2010, revealed
"...Location (of the pain): (no) c/o (complaints) of
pain at this time. Hx: neck, bil (bilateral) leg,
back, bil shoulder...Intensity: (0-10 scale) not
present, worse pain gets 8...What relieves pain:
"pain pill I get 3 times a day"...Plan:
Hydrocodone-APAP 5/500 one po TID (by mouth
three times daily)..."
**NAME OF PROVIDER OR SUPPLIER**
BLEDSOE COUNTY NURSING HOME

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**SUMMARY STATEMENT OF DEFICIENCIES**

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<th>COMPLETION DATE</th>
</tr>
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</table>
| F 514  | Continued From page 27
Medical record review of the physician order initiated on May 14, 2010, current to the present date, revealed "...Hydrocodone (pain medication)...5/500 take one tablet every 8 hours as needed (PRN) for pain..."

Medical record review of the Medication Administration Record (MAR) revealed the following:
- December 2010: twenty-nine administrations of the medication.
- February 2011: thirty-five administrations of the medication.
- March 2011: thirty-nine administrations of the medication.

Medical record review of the back of the MAR revealed "...Instructions...d. PRN Med: Reason given and results should be noted on Nurse's Medication Notes..." Further review revealed Nurse's Medication Notes including date/hour, medication/dosage, reason, result/response, and hour/init. Further review revealed the following:
- December 2010: seventeen of the twenty-nine administrations lacked documentation under the Nurse's Medication Notes. Further review revealed on December 10, 2010, Nurse's Medication Notes documented PRN Hydrocodone was administered at 9:00 p.m. but the MAR lacked documentation of this administration.
- January 2011: eight of the twenty-nine administrations lacked documentation under the Nurse's Medication Notes. Further review of the Nurse's Medication Notes revealed on January 3, 2011 at 8:00 a.m., and January 4, 2011, no time.

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3.) **WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?**

Inservice was conducted by the Director of Nursing on 4/4/11. PRN Documentation policy was inserviced at that time. Wong-Baker Pain Scale was put into effect beginning 4/4/11 for all PRN pain medications to identify the intensity of the pain as well as the effectiveness of the pain medication.
4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?

MARs will be monitored weekly by the Director of Nursing or the MDS Coordinator for complete documentation of PRN medications including intensity. This will be monitored by the QA Committee for 6 months or as deemed necessary by the committee.

QA Committee: Director of Nursing; MDS Coordinator; Dietary Supervisor; Social Services Director; Administrator; Pharmacist; Medical Director; Floor Nurse and C.N.A.
Continued From page 29

Interview confirmed the front of the MAR did not correspond with the Nurse’s Note on the back of the MAR to validate the administration of the PRN Hydrocodone and the medical record was not accurate.

Interview, on March 24, 2011, at 7:54 a.m. with the DON in the Chapel confirmed the facility did not have a policy addressing PRN mediation and trained the staff verbally on the policies.