An annual Recertification survey and Complaint investigation #28214 were completed at Life Care Center of Crossville on June 27 through 29, 2011. No deficiencies were cited related to Complaint #28214 under 42 CFR PART 482.13, Requirements for Long Term Care Facilities.

**F 281** 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to follow physicians orders for two (#2, #13) of twenty-four residents reviewed.

The findings included:

Resident #2 was admitted to the facility on November 26, 2008, with diagnoses including Failure to Thrive, Senile Dementia, Hypertension, and Depression. Review of the Minimum Data Set (MDS) dated May 3, 2011, revealed the resident had severe cognitive impairment, was non-ambulatory, and dependent on staff for personal hygiene and bathing activities.

Review of the resident’s Fall Risk Evaluation dated May 4, 2011, revealed the resident was at risk for falls. Review of the resident’s care plan dated November 15, 2010, revealed the resident used the wheelchair most of the day for locomotion.

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<th>ID</th>
<th>PREFIX</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<td>INITIAL COMMENTS</td>
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**F 281**

A. What corrective action(s) will be accomplished for those residents found to have been affected: On 6/28/11, CNA applied hipsters and cushion in wheelchair for resident #2. On same date, ADON applied heel protectors and footed socks for resident #13.

B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

Audit of residents was completed 6/28/11 by RN unit managers to ensure compliance with physician orders for pressure relieving products in bed/chair/other. Corrections were made as needed.
Review of the resident's care plan for skin integrity dated November 15, 2010, revealed the resident had potential for skin breakdown and "...Place pressure relieving product on bed/Chair/other...".

Review of the Physician's Orders (the monthly recapitulation orders) dated June 1 through June 30, 2011, revealed "...Hipsters (hip pads) to be worn at all times....." and "...Place in wc (wheelchair) with cushion when out of bed...

Observation of the resident on June 27, 2011, at 1:15 p.m., and June 28, 2011, at 2:45 p.m., revealed the resident up in the wheelchair without hipsters and without the use of the cushion in the wheelchair.

Interview with the Licensed Practical Nurse (LPN) #2 on June 29, 2011, at 2:45 p.m., in the resident's room confirmed the physician's orders had not been followed with regard to the use of the cushion in the wheelchair and hipsters.

Resident #13 was readmitted to the facility on March 3, 2011, with diagnoses including Acute Care Traumatic Fracture Hip, Mental Disorder, Alzheimer's disease, Psychosis, Hypertension, Depression Disorder, Cellulitis Arm, and Adult Failure to thrive.

Medical record review of the Minimum Data Set dated May 30, 2011, revealed the resident had difficulty with long and short term memory, severe cognitive impairment, was non-ambulatory, and required assistance with all activities of daily living.

C. What measures will be put into place to ensure the deficient practice will not recur?

Director of Nursing to complete education with RN/LPN/CNA associates by 7/21/11 to ensure compliance with physician orders for pressure relief products in bed/Chair/other. Room-to-room observation audit will be completed twice weekly for first month, then weekly for two months by unit managers, MDS nurses, and wound care nurse to ensure compliance with physician orders for pressure relieving products in bed/Chair/other. Corrections will be made at time of audit if needed.

D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

Results of physician order audits will be reported and reviewed by Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff Development Coordinator in Monthly QA meeting and corrections made as needed.
F 281  Continued From page 2

Medical record review of the physician’s recapitulation orders dated June 2011 revealed “Heel protectors on while in bed.. Float heels with a pillow at all times.”

Observation on June 28, 2011, at 9:15 a.m., with the Assistant Director of Nursing (ADON) revealed the resident in bed wearing a leg splint on the right leg and wearing tight fitting socks on both feet which had developed foot drop. Continued observation revealed the resident had two open areas on the top of the 2nd and 3rd toes on the left foot. Continued observation revealed one heel protector lying in the chair at the foot of the resident’s bed and the second heel protector was not found in the room. Continued observation revealed the resident's feet were not floating on a pillow.

Interview with the ADON on June 28, 2011, at 9:15 a.m., in the resident’s room confirmed the physician’s orders were not followed.

F 312  S5=D

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to provide nail care for two (#2, #13) of twenty-four residents

F 312  8/8/2011

A. What corrective action(s) will be accomplished for those residents found to have been affected:
Finger nails of resident #2 were cut 6/28/11 by CNA and toe nails of resident #13 were cut 6/28/11 by LPN.

B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?
RN Unit Managers completed audit of all residents’ finger and toe nail care 7/12/11. Nails were trimmed if needed.

3/3/2011
F 312 Continued From page 3 reviewed.

The findings included:

Resident #2 was admitted to the facility on November 28, 2006, with diagnoses including Failure to Thrive, Senile Dementia, Hypertension, and Depression. Review of the Minimum Data Set (MDS) dated May 3, 2011, revealed the resident had severe cognitive impairment, was non-ambulatory, and dependent on staff for personal hygiene and bathing activities.

Observation of the resident's fingernails on June 27, 2011, at 1:15 p.m., and June 28, 2011, at 7:45 a.m., revealed the resident's fingernails were long. Observation on June 28, 2011, at 10:45 a.m., revealed the resident entered the shower room with a Certified Nurse Assistant to receive a shower. Observation after the resident's shower on June 28, 2011, at 2:45 p.m., revealed the resident's fingernails were long.

Interview with the Licensed Practical Nurse (LPN) #2 in the resident's room on June 28, 2011, at 2:45 p.m., confirmed the resident's fingernails were long and needed to be trimmed.

Resident #13 was readmitted to the facility on March 3, 2011, with diagnoses including Aftercare Traumatic Fracture Hip, Mental Disorder, Alzheimer's disease, Psychosis, Hypertension, Depression Disorder, Cellulitis Arm, and Adult Failure to thrive.

Medical record review of the Minimum Data Set dated May 30, 2011, revealed the resident had
F 312 Continued From page 4

difficulty with long and short term memory, severe
cognitive impairment, was non-ambulatory, and
required assistance with all activities of daily
living.

Observation on June 26, 2011, at 9:15 a.m., with
the Assistant Director of Nursing (ADON)
revealed the resident in bed wearing a leg splint
on the right leg and wearing tight fitting socks on
both feet which had developed foot drop.
Continued observation revealed the resident had
two open areas on the top of the 2nd and 3rd
toes on the left foot. Continued observation
revealed the resident's toenails on the left foot
were thick, long, and curved under the resident's
toes.

Interview with the ADON on June 26, 2011, at
9:15 a.m., in the resident's room, confirmed the
resident's toenails were thick, long, and had
curved under the resident's toes and needed to
be trimmed.

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:

F 371

A. What corrective action(s) will be accomplished
for those residents found to have been affected?
A steel fabricating contractor evaluated walk-in
refrigerator 7/11/11 for aluminum plates for areas
affected by rust. Steel fabrication repairs will be
completed 8/8/11.

B. How will you identify other residents
having the potential to be affected by
the same deficient practice and what corrective
action will be taken?
Dietary Manager will complete education with
dietary associates by 7/21/11 to ensure that
rusted equipment is reported to supervisor.

8/8/2011
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CAU IDENTIFICATION NUMBER: 445167

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ________________
B. WING ________________

(X3) DATE SURVEY COMPLETED 06/29/2011

NAME OF PROVIDER OR SUPPLIER

LIFE CARE CENTER OF CROSSVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE
80 JUSTICE ST
CROSSVILLE, TN 38555

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 371 Continued From page 5
Based on observation and interview, the facility failed to maintain the dietary department walk-in refrigerator in proper repair.

The findings included:

Observation on June 27, 2011, at 8:58 a.m., with the Certified Dietary Manager present revealed the walk-in refrigerator floor was covered with rust. Further observation revealed the rust had penetrated the surface of the metal floor resulting in irregular multiple layers of rusted flooring. Further observation revealed rust had penetrated the metal surface of the door jam, from the refrigerator floor upward, of the walk-in refrigerator.

Interview on June 27, 2011, at 8:58 a.m., with the Certified Dietary Manager confirmed the walk-in refrigerator floor was covered with rust. Further interview confirmed the rust had penetrated the surface of the floor covering and the metal surface of the door jam of the walk-in refrigerator.

F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it-
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation,
### F 441

**Continued From page 6**

1. Should be applied to an individual resident; and
2. Maintains a record of incidents and corrective actions related to infections.
3. Preventing Spread of Infection
   1. When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
   2. The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
   3. The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.
4. Linens
   - Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

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

- Based on medical record review, observation, policy review, and interview, the facility failed to maintain nasal cannula storage in a manner to prevent infection for three residents (#11, #17, #18); and failed to maintain a clean fan in a manner to prevent infection for one resident (#24) of twenty-four residents reviewed.

The findings included:

- Resident #11 was admitted to the facility on
F 441 Continued

November 29, 2010, and readmitted on February 10, 2011, with diagnoses including Mental Disorder and Diabetes Mellitus.

Observation on June 27, 2011, at 9:20 a.m., and 12:53 p.m., revealed an oxygen concentrator with a coiled nasal cannula stored on the concentrator.

Interview with Certified Nurse Aide #2 on June 27, 2011, at 12:53 p.m., in the resident’s room confirmed the nasal cannula should be stored in a bag when not in use.

Resident #17 was admitted to the facility on January 7, 2010, and readmitted on March 4, 2010, with diagnoses including Chronic Obstructive Pulmonary Disease, Late Effect Cerebrovascular Accident with Right Hemiparesis, and Anxiety.

Observation on June 27, 2011, at 9:30 a.m., revealed the resident in the bed, the oxygen concentrator was in operation, and the nasal cannula was in direct contact with the floor.

Interview on June 27, 2011, at 9:30 a.m., with Certified Nurse Aide #1, in the resident’s room, confirmed the nasal cannula was to be stored in a bag when not in use.

Observation on June 28, 2011, at 1:00 p.m., revealed the resident in bed, both full side rails in the upright position, the oxygen concentrator was in operation, the oxygen tubing was draped over the side rail, and the nasal cannula was in direct contact with the interior surface of the trash can.

F 441 Continued

D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

Results of nasal cannula and fan audits will be reported and reviewed by Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff Development Coordinator in Monthly QA meeting and corrections made as needed.

8/8/2011
<table>
<thead>
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<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>F 441</td>
<td>Continued From page 8</td>
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Resident #18 was admitted to the facility on April 27, 2011, with diagnoses including Chronic Obstructive Pulmonary Disease, Sleep Apnea, Congestive Heart Failure, and Diabetes Mellitus.

Observation on June 28, 2011, at 2:35 p.m., revealed the resident in the bed, the oxygen concentrator was in operation, and the nasal cannula was in direct contact with the floor.

Interview with Licensed Practical Nurse #1 on June 28, 2011, at 2:38 p.m., in the resident's room, confirmed the nasal cannula was to be stored in a bag when not in use.

Review of facility policy Oxygen Therapy-Mask & (and) Nasal Cannula revealed "...Procedure...4. When masks and cannulas are not in use, store in a plastic bag."

Interview with the administrator in the conference room, on June 28, 2011, at 4:00 p.m., confirmed the facility failed to follow the policy to store nasal cannulas in a bag when not in use.

Resident #24 was admitted to the facility on April 6, 2010, and readmitted on April 4, 2011, with diagnoses including Chronic Obstructive Pulmonary Disease, Acute Bronchitis, Asthma, Dependent Supplement Oxygen, and Depressive Disorder.

Observation on June 28, 2011, at 2:35 p.m., revealed the resident in the bed, the oxygen concentrator was in operation, the nasal cannula
Continued from page 9

was placed on the resident, and a table top fan was blowing directly onto the resident. Further observation revealed the fan grate had an accumulation of hanging debris. After stopping the fan, observation revealed the fan blades were covered with an accumulation of blackened debris.

Interview with the resident, at 2:35 p.m., on June 28, 2011, in the resident's room, confirmed the fan was the resident's personal property and it (fan) "was dirty."

Interview with the administrator, on June 28, 2011, at 2:37 p.m., in the resident's room, confirmed the fan grate and blades were not clean.