PRELIMINARY COMMENTS

Complaint investigation numbers 28555 and 27917 were completed during the annual Recertification Survey at Consulate Health Care of Chattanooga on May 2-4, 2011. No deficiencies related to the complaints were cited under 42 CFR PART 483.13, Requirements for Long Term Care.

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 and interview, the facility failed to ensure monthly recaptulation orders were accurate for nineteen (#2, #9, #14, #20, #21, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #36, #37, #38, #14, #17) of thirty eight residents reviewed.

The findings included:

Medical record review of resident #2's May 2011, recaptulation orders revealed "...Aspirin (Baby) 81 mg (milligram) tablet EC (Enteric Coated) for Bayer Aspirin EC 1 tab by mouth every day ...

Medical record review of resident #9's May 2011, recaptulation orders revealed "...Aspirin (Baby) 81 mg (milligram) tablet EC (Enteric Coated) for Bayer Aspirin EC 1 tab by mouth every day ...

Medical record review of resident #14's May 2011, recaptulation orders revealed "...Aspirin ...
Continued From page 1
(Baby) 81 mg (milligram) tablet EC (Enteric Coated) for Bayer Aspirin EC 1 tab by mouth every day ...

Medical record review of resident #20's May 2011, recaptulation orders revealed "...Aspirin (Baby) 81 mg, tablet EC for >Bayer Aspirin EC 1 tab by mouth every day ...

Medical record review of Resident #21's May 2011, recaptulation orders revealed "...Aspirin-low 81mg tablet DR for Bayer Aspirin EC (Enteric Coated) take 1 tab by mouth every day ...

Medical record review of Resident #25's May 2011, recaptulation orders revealed "...Aspirin-low 81mg tablet DR for Bayer Aspirin EC (Enteric Coated) take 1 tab by mouth every day ...

Medical record review of resident #26's May 2011, recaptulation orders revealed "...Aspirin (Baby) 81 mg (milligram) tablet EC (Enteric Coated) for> Bayer Aspirin EC 1 tab by mouth every day ...

Medical record review of resident #27's May 2011, recaptulation orders revealed "...Aspirin (Baby) 81 mg (milligram) tablet EC (Enteric Coated) for> Bayer Aspirin EC 1 tab by mouth every day ...

Medical record review of resident #28's May 2011, recaptulation orders revealed "...Aspirin (Baby) 81 mg (milligram) tablet EC (Enteric Coated) for> Bayer Aspirin EC 1 tab by mouth every day ...

Medical record review of Resident #29's May
CONSULATE HEALTHCARE OF CHATTANOOGA

10. Resident #29 Clarification order per NP:
   D/C Aspirin-low 81 mg tablet DR for Bayer Aspirin EC (Enteric Coated) takes 1 tab by mouth every day.
   New Order: ASA 81 mg 1 po q day (chewable)

11. Resident #30 Clarification order per NP:
   D/C Aspirin (Baby) 81 mg (milligram) tablet EC (Enteric Coated) for > Bayer Aspirin EC 1 tab by mouth every day.
   New Order: Continue ASA 81 mg EC 1 po q day

12. Resident #31 Clarification order per NP:
   D/C Aspirin (Baby) 81 mg (milligram) tablet EC (Enteric Coated) for > Bayer Aspirin EC 1 tab by mouth every day.
   New Order: Continue ASA 81 mg EC 1 po q day

13. Resident #32 Clarification order per NP:
   D/C Aspirin-low 81 mg tablet DR for Bayer Aspirin EC (Enteric Coated) takes 1 tab by mouth every day.
   New Orders: 81 mg aspirin 1 po qD (chewable)

14. Resident #33 Clarification order per NP:
   D/C Aspirin-low 81 mg tablet DR for Bayer Aspirin EC (Enteric Coated) takes 1 tab by mouth every day.
   New Orders: ASA 81 mg 1 po daily (chewable)

15. Resident #34 Clarification order per NP:
   D/C Aspirin (Baby) 81 mg (milligram) tablet EC (Enteric Coated) for > Bayer Aspirin EC 1 tab by mouth every day.
   New Order: Continue ASA 81 mg EC 1 po q day

16. Resident #36 Clarification order per NP:
   D/C Aspirin (house) 81 mg (milligram) tablet EC (Enteric Coated) for > Bayer Aspirin EC 1 tab by mouth every day
   New Order: Continue ASA 81 mg EC 1 po q day
F 281 Continued From page 3

Medical record review of resident #37's May 2011, recapture orders revealed "...Aspirin (house) 81 mg (milligram) tablet EC (Enteric Coated) for > Bayer Aspirin EC 1 tab by mouth every day ..."

Medical record review of resident #38's May 2011, recapture orders revealed "...Aspirin (Baby) 81 mg (milligram) tablet EC (Enteric Coated) for > Bayer Aspirin EC 1 tab by mouth every day ..."

Interview on May 4, 2011, at 10:00 a.m., in the conference room with the Pharmacist Consultant and the Director of Clinical Services revealed the pharmacy inputs the physician's orders and prints the monthly recapture orders. Continued interview confirmed the May 2011, recapture orders were inaccurate and stated the nineteen residents were to receive enteric coated aspirin, and the original physician orders stated chewable/house aspirin. Continued interview confirmed the nurse's did not check the original physician's orders to ensure accuracy of the May 2011, recapture orders.

Medical record review of resident #17's May 2011, recapture orders revealed "...Isosorbide Mononitrate 20mg tablet...take 2 tabs by mouth every day ..."

Medical record review of the hospital return physician's orders dated April 17, 2011, revealed "...Isosorbide Mononitrate 20mg tablet...take 1 tab by mouth every day ..."

Interview and review of resident #17's May 2011, recapture orders and hospital return
Continued From page 4

physician's orders on May 3, 2011, at 8:10 a.m., with Registered Nurse #4, outside of the resident's room revealed the May 2011, recaptulation orders were inaccurate, did not reflect the April 17, 2011, hospital return physician's orders, reducing the Isosorbide Mononitrate 20mg from two to one tablets daily.

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 grooming for one (#1) of thirty-eight residents reviewed.

The findings included:

Resident #1 was admitted to the facility on January 28, 2011, with diagnoses including Palliative Care, Alzheimer's Dementia, and Urinary Tract Infection (UTI).

Medical record review of the Minimum Data Set dated April 4, 2011, revealed the resident had impaired short and long term memory and required assistance with all activities of daily living.

Observation on May 3, 2011, at 1:20 p.m., in the

The facility will ensure each resident who is unable to carry out activities of daily living receives the necessary services to maintain grooming.

1. Resident #1 nails and toe nails were trimmed and cleaned, and facial hair removed by the West Unit 1 Charge Nurse under the West Unit Manager supervision on 5/5/2011.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEG IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>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>
</tr>
</thead>
<tbody>
<tr>
<td>F 312</td>
<td></td>
<td>Continued From page 5 resident's room revealed the resident's finger nails had dark debris under the finger tips, and the resident's toe nails were approximately ½ centimeter past the toe tips. Continued observation revealed approximately ten 1 inch long hairs on the resident's chin. Observation and interview on May 4, 2011, at 10:10 a.m., with Registered Nurse (RN) #2 in the resident's room revealed the resident had a shower on the evening shift May 3, 2011, and the resident's finger nails had dark debris under the finger tips, the resident's toe nails were approximately ½ centimeter past the toe tips and the resident had approximately ten 1 inch hairs on the chin. Continued interview confirmed the resident's finger nails required cleaning, the resident's toe nails required trimming and the resident required assistance to remove the chin hairs.</td>
<td>F 312</td>
<td></td>
<td>2. Residents will be monitored during ADL care for long nails, toe nails, facial hair present and will be cleaned and trimmed as needed. 3. The Director of Clinical Services and/or Director will conduct in-services for nursing and ADL staff on 5/15/2011, 5/17/2011, 5/18/2011, 5/19/2011 concerning ADL's with nail grooming, facial hair and hygiene. 4. The Director of Clinical Services, Unit Manager, and/or Charge Nurse will monitor resident's appearance during rounds and document for appropriate resident nail grooming and facial hair.</td>
<td>5/15/2011</td>
</tr>
<tr>
<td>F 315</td>
<td>483.25(d)</td>
<td>NO CATHETER, PREVENT UTI, RESTORE BLADDER</td>
<td>F 315</td>
<td></td>
<td>The facility will ensure each 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>
<td></td>
</tr>
<tr>
<td></td>
<td>SS=D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<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>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
F 315: Continued From page 6

Review of facility policy, and interview, the facility failed to provide appropriate perineal care for three residents (#1, #2, #5) and failed to complete the assessment to re-train a resident to improve continence for one (#11) of thirty-eight residents reviewed.

The findings included:

Resident #1 was admitted to the facility on January 28, 2011, with diagnoses including Palliative Care, Alzheimer's Dementia, and Urinary Tract Infection (UTI).

Medical record review of the Minimum Data Set (MDS) dated April 4, 2011, revealed the resident had impaired short and long term memory, was incontinent of bowel and bladder, and required assistance with all activities of daily living.

Medical record review of the hospital History and Physical dated March 23, 2011, revealed the resident was admitted to the hospital with early Sepsis from a UTI, caused by Escherichia Coli (E. Coli) (bacteria found in the bowel).

Observation on May 3, 2011, at 1:20 p.m., in the resident's bathroom revealed Certified Nurse Assistant (CNA) #1 assisted the resident to stand (after urinating and having a bowel movement) from sitting on the toilet. Continued observation revealed CNA #1 used a towel wet with water and washed the resident's perineal area.

Resident #2 was admitted to the facility on April 5, 2010, with diagnoses including Difficulty walking, Hemiplegia (weakness on one side of the body),
F.315 Continued from page 7

and had recent diagnoses of UTI.

Medical record review of the MDS dated February 25, 2011, revealed the resident had impaired short and long term memory, was incontinent of bowel and bladder, and required assistance with all activities of daily living.

Medical record review of the laboratory results dated March 17, 2011, revealed the resident had a UTI.

Observation on May 2, 2011, at 1:30 p.m., in the resident's room revealed CNA #2 and CNA #3 assisted the resident with perineal care. Continued observation revealed the resident was incontinent of bladder and had a small amount of bowel movement. Continued observation revealed CNA #3 assisted the resident onto the back, removed the soiled brief, and CNA #2 took a wet baby wipe and wiped on each side between the leg and labia, then without turning the wipe wiped downward between the labia.

Interview on May 2, 2011, at 1:40 p.m., with CNA #2 outside of the resident's room confirmed CNA #2 wiped on each side between the leg and labia, then without turning the wipe wiped downward between the labia.

Resident #5 was admitted to the facility on February 14, 2011, with diagnoses including Difficultly Walking, Dementia With Behaviors, and Acute Renal Failure.

Medical record review of the MDS dated March 29, 2011, revealed the resident had impaired...
F 315
Continued From page 8
short and long term memory, required assistance with all activities of daily living, and was incontinent of bowel and bladder.

Observation on May 2, 2011, at 1:30 p.m., in the resident's room revealed CNA #2 and CNA #3 assisted the resident with perineal care. Continued observation revealed the resident was incontinent of bladder. Continued observation revealed CNA #3 assisted the resident on the back, removed the soiled brief, and CNA #2 took a wet baby wipe and wiped on each side between the leg and labia, then without turning the wipe wiped downward between the labia.

Review of the facility's Perineal Care policy and procedure revealed "...rinse perineal area with soap and water..."

Interview on May 4, 2011, at 10:05 a.m., with the Director of Clinical Services in the conference room confirmed the three resident's perineal care was not performed appropriately to prevent UTTS.

Resident #11 was admitted to the facility on January 26, 2011, with diagnoses including Myocardial Infarction, Deep Vein Thrombosis, and Acute Renal Failure.

Observation on May 3, 2011, at 9:35 a.m., revealed resident #11 sitting in the wheelchair in the room. Continued observation revealed the resident "some of the time" was aware of urge to go to the bathroom to empty the bladder, and was "almost all the time" aware of the need to go to the bathroom for a bowel movement. The resident
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 315</td>
<td>Continued From page 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

stated, "I have not made it to the bathroom for BM (bowel movement) twice while I was waiting for help...I am in a wheelchair."

Medical record review of the Admission Data Collection Form dated January 26, 2011, revealed the resident was alert, short and long-term memory was without problems; had modified independence with cognitive skills for decision making; required one-person assist for transfers; and was continent of bowel and usually continent of bladder.

Review of the form Potential for Bowel/Bladder (B & B) Training dated January 26, 2011, revealed resident #11 scored "16". Review of the form revealed a score of 15-21 indicated the resident was a "good candidate for individualized training". Review of the form revealed a handwritten note which read, "Needs 3 day B & B assessment" and signed by the Staff Development Coordinator (SDC).

Medical record review revealed no documentation of a three day bowel and bladder assessment.

Review of the form Potential for Bowel/Bladder Training dated April 18, 2011, revealed resident #11 received a score of "8"; a decline in status from a score of 16 on admission. Review of the form revealed a score of 7-14 indicated the resident was a "candidate for toileting schedule (timed void)."

Review of the facility policy titled Bladder Independence/Retraining revised January 2011, revealed, "A Potential for Bowel/Bladder Training

2. Resident #11 was assessed by the Education Coordinator and placed on a 3-day re-training program on 5/8/2011 after assessment of toileting routine.

3. Residents with incontinence were reviewed by the Education Coordinator on 5/3/2011.
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>F 315</th>
</tr>
</thead>
<tbody>
<tr>
<td>(X4)</td>
<td>PREFIX</td>
<td>F315</td>
</tr>
<tr>
<td>F315</td>
<td></td>
<td>Continued From page 10 form will be completed. A resident that receives a score of 15-21 are considered good candidates for retraining. Information will be gathered by completing the Incontinence Data Collection Tool. An observation of resident voiding times will determine residents who have potential for improved bladder training.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Interview in the conference room with the Staff Development Coordinator (SDC #1) on May 3, 2011, at 10:07 a.m., verified resident #11 did receive a score which indicated a three day assessment and confirmed the facility failed to perform the three day bowel and bladder assessment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Interview with the Director of Clinical Services in the conference room on May 3, 2011, at 10:18 a.m., verified resident had a decline in bowel and bladder function from admission and confirmed the facility failed to complete the assessment which was a required step for retraining.</td>
</tr>
<tr>
<td>F332</td>
<td>SS=D</td>
<td>F332</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F332 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The facility must ensure that it is free of medication error rates of five percent or greater.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to administer four of forty-four medications without error resulting in a nine percent medication error rate.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The findings included:</td>
</tr>
</tbody>
</table>

**Consulate Health Care of Chattanooga**

- **Street Address, City, State, Zip Code:** 8245 Standifer Gap Road, Chattanooga, TN 37421

**Date Survey Completed:** 05/04/2011

---

**Consulate Health Care of Chattanooga**

- **Street Address, City, State, Zip Code:** 8245 Standifer Gap Road, Chattanooga, TN 37421

**Date Survey Completed:** 05/04/2011

---

**Consulate Health Care of Chattanooga**

- **Street Address, City, State, Zip Code:** 8245 Standifer Gap Road, Chattanooga, TN 37421

**Date Survey Completed:** 05/04/2011

---

**Consulate Health Care of Chattanooga**

- **Street Address, City, State, Zip Code:** 8245 Standifer Gap Road, Chattanooga, TN 37421

**Date Survey Completed:** 05/04/2011
F 332 Continued From page 11

Medical record review of resident #18's May 2011, physician's orders revealed "...Propranolol HCL UD take 3 tabs (30 mg) (milligram) by mouth twice daily record apical pulse prior to admin. Hold if pulse <60..."

Observation on May 2, 2011, at 4:10 p.m., in the resident's room revealed Registered Nurse (RN) #3 administered one Propranolol 30 mg without obtaining resident #18's apical pulse prior to administration.

Interview on May 2, 2011, at 4:20 p.m., outside of the resident's room confirmed the apical pulse was not obtained and recorded prior to administering the Propranolol 30 mg as the physician ordered.

Medical record review of resident #4's May 2011, physician's orders revealed "...Hydrocodone/Acetaminophen 5-500 tablet...take one tablet two times a day..."

Observation on May 2, 2011, at 4:17 p.m., in resident #4's room revealed RN #3 failed to administer the Hydrocodone 5/500 mg.

Interview on May 2, 2011, at 4:20 p.m., in the resident's hallway with RN #3 confirmed the Hydrocodone/Acetaminophen 5-500mg was not administered as ordered by the resident's physician.

Medical record review of Resident #21's May 2011, physician's orders revealed "...Aspirin-low 81mg tablet DR for Bayer Aspirin EC (Enteric Coated) take 1 tab by mouth every day..."
F 332. Continued From page 12

Observation on May 3, 2011, at 7:35 a.m., in resident #21’s room revealed Licensed Practical Nurse (LPN) #1 administered one Aspirin 81mg chewable to resident #21.

Interview on May 3, 2011, at 7:55 a.m., in the hallway near resident #21’s room confirmed LPN #1 administered one chewable Aspirin tablet and the physician’s order stated to administer one Enteric Coated Aspirin 81 mg.

Medical record review of resident #17’s May physician’s orders revealed “...Isosorbide Mononitrate 20 mg tablet...take 2 tabs by mouth every day.”

Observation on May 3, 2011, at 8:00 a.m., in resident #17’s room revealed RN #4 administered one Isosorbide Mononitrate 20 mg tablet to resident #17.

Interview on May 3, 2011, at 8:10 a.m., with RN #4 outside of resident #17’s room confirmed one Isosorbide Mononitrate 20 mg tablet was administered to resident #17, and the May 2011 physician’s orders stated to administer two Isosorbide Mononitrate 20 mg tablets.

5. Resident #21 Clarification order per NP:
D/C Aspirin low 81 mg tablet DR for Bayer Aspirin EC (Enteric Coated) take 1 tab by mouth every day.

New order: Start Aspirin 81 mg po QD chewable.

6. Resident #17 Clarification order per NP:
D/C Isosorbide Mononitrate 20 mg tab q.d. for Bayer Aspirin EC (Enteric Coated) take 1 tab by mouth every day.

New orders: Isosorbide Mononitrate 20 mg po daily.


8. The Director of Clinical Services, Administrator, and Unit Managers will meet with Pharmacy Director, Pharmacist, and Pharmacy staff representative, and will develop a QM plan to monitor and address the resident’s monthly medication orders, 5/16/2011. Pharmacy will participate in the monthly medication orders with the staff at CHC. Variance will be corrected and recollection nursing staff will be re-educated and/or counseled. Variance will be reported and discussed at the Monthly Quality Assurance Meeting.

Substantial Compliance 6/15/2011