F 000 INITIAL COMMENTS

An annual Recertification survey and Complaint investigation #s 27098, 27539, 28215, 28232 were completed at Life Care of Rhea County on January 9-11, 2012. No deficiencies were cited related to complaint investigation # s 27098, 27539, 28215, 28232, under 42 CFR PART 482.13, Regulations for Long Term Care.

F 164 SS=D

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

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 insufficient for continued program participation.
**F 164** Continued From page 1

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

Based on medical record review, observation, and interview, the facility failed to honor a resident's right to privacy for one resident (#1) of eighteen residents reviewed.

The findings included:

Resident #1 was admitted to the facility on February 24, 2011, with diagnoses including Parkinson's Disease, Dementia, Anemia, Transient Ischemic Attack, and Chronic Lymphocytic Leukemia.

Medical Record review of the Minimum Data Set (MDS) dated November 8, 2011, revealed the resident was totally dependent for activities of daily living (ADL) and was incontinent of bowel.

Observation on January 9, 2012, at 10:20 a.m., in the resident's room, revealed the resident lying on the left side of the body facing the outside window well. Continued observation revealed the resident was receiving perineal care (washing of genital and rectal areas) for bowel incontinence by Certified Nursing Assistant (CNA) #1 and CNA #2. Continued observation revealed the privacy curtain was open and the resident was uncovered while perineal care was being performed.

Continued observation revealed the resident's roommate was sitting in a wheelchair facing the resident and observing the perineal care.

Interview with the Director of Nursing (DON) on January 10, 2012, at 1:52 p.m., in the hallway...
Continued From page 2 outside the Administrator's Office, confirmed a resident's privacy curtain was to be closed when personal care is performed.

F 332 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE

The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:

Based on observation, medical record review, review of manufacturer's specifications, facility policy, and interview, the facility failed to prevent medication errors less than five percent resulting in four errors within forty-six opportunities to equal an error rate of eight percent.

Observations revealed errors occurred with one (Licensed Practical Nurse [LPN] #1) of five LPNs, one (New Side Hall) of two halls, one (Medication Cart #2) of three medication carts, one (6 a.m., to 2 p.m.) of three shifts, and two (#10, #8) of eleven residents observed.

The findings included:

Medication Error #1

Observation on January 9, 2012, at 9:33 a.m., at the Medication Cart #2, revealed LPN #1 administered one Metformin 500 mg (milligram) tablet for Diabetes to Resident #10.

Medical record review of the January 2012 Recapitulation orders for Resident #10 revealed an order for "...METFORMIN...500MG"
F 332 Continued From page 3

TABLET...TAKE 1 TAB (tablet) BY MOUTH EVERY MORNING...


Review of the facility's policy, "Food/Water Recommendations for Certain Drugs", page 9-18 revealed Metformin was to be administered "With Food"

Interview with LPN #1 on January 9, 2012, at 10:11 a.m., at the Medication Cart #2 outside resident rooms 23 and 24. In the New Side Front Hallway confirmed Resident #10 was not eating food at the time the Metformin was administered; the breakfast tray for Resident #10 was served on January 9, 2012, between 7:30 a.m. and 8:00 a.m.; and one medication error occurred when the Metformin tablet was not administered with food and approximately one hour and thirty minutes after breakfast was served.

Interview with the Director of Nutritional Services on January 10, 2012, at 10:20 a.m., in the MDS (Minimum Data Set) office confirmed breakfast trays were served to the residents beginning at 7:30 a.m., and lunch trays were served to the residents beginning at 11:30 a.m., on January 9, 2012; and no other meal trays were served between breakfast and lunch.

Medication Error #2

Observation on January 9, 2012, at 9:44 a.m., at F 332

Identify residents that have the potential to be affected by the alleged deficient practice.

a) All residents that receive insulin, medications to be given with food, medications to be diluted or medications that are not to be crushed could be affected.

b) 100% audit of all residents that receive insulin, medications to be given with food, medications to be diluted or medications that are not to be crushed could be affected was completed by Assistant Director of Nursing on 1/27/2012. No other residents were affected.

What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur?

a) All licensed personnel were reinserviced on insulin administration, medications to be given with food, dilution of medications and medication not to be crushed on 1/9/2012 and 1/26/2012 by staff development coordinator.

b) A list of "do not crush" medications, medications to be diluted in water or juice, insulin perimeters, and medications to be given with food was placed on each medication administration record binder.

c) Medication pass procedure will be observed weekly for 4 weeks then monthly for two months by the Director of Nursing or Staff Development Coordinator or pharmacy representative for compliance.
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<tr>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tbody>
<tr>
<td>F 332</td>
<td>Continued From page 4 the Medication Cart #2, revealed LPN #1 administered 3 units of Humulin R Injectable Insulin 100 units per ml (milliliter) for Diabetes subcutaneously (under the skin) to the upper quadrant of the right arm of Resident #6. Medical record review of the January 2012 Recapitulation orders for Resident #6 revealed an order for &quot;...Humulin R 100UNIT/1ML (milliliter) VIAL...&quot; per sliding scale insulin &quot;...FOUR TIMES DAILY...&quot; Review of the manufacturer's specification for Humulin R Insulin revealed, &quot;...The injection of Humulin R U-100 should be followed by a meal within approximately 30 minutes of administration...&quot; Interview with LPN #1 on January 9, 2012, at 10:09 a.m., at Medication Cart #2 outside resident rooms 23 and 24 in the New Side Front Hallway confirmed the breakfast tray for Resident #6 was served on January 9, 2012, between 7:30 a.m., and 8:00 a.m., and one medication error occurred when the Humulin R was not administered &quot;thirty minutes before a meal&quot; and approximately one hour and forty minutes after breakfast was served. Interview with the Director of Nutritional Services on January 10, 2012, at 10:20 a.m., in the MDS office confirmed breakfast trays were served to the residents beginning at 7:30 a.m., and lunch trays were served to the residents beginning at 11:30 a.m., on January 9, 2012, and no other meal trays were served between breakfast and lunch.</td>
<td>F 332</td>
<td>d) The DON or Nursing Home Administrator will review the Medication pass procedure observations starting on 1/27/2012 to 2/17/2012 and weekly for two months.</td>
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F 332 Continued From page 5
Medication Error #3

Observation on January 9, 2012, at 9:44 a.m., at the Medication Cart #2, revealed LPN #1 administered 16 mls (20 meq [milliequivalents]) of Potassium Chloride Solution for potassium replacement by mouth to Resident #6.

Medical record review of the January 2012, Recapitulation orders for Resident #6 revealed an order for "...KCL (Potassium Chloride) 20 meq po (by mouth) BID (twice daily)"

Review of the pharmacy prescription label for Potassium Chloride Solution dispensed on December 22, 2011, to Resident #6 revealed administration instructions to "...Take with plenty of water. Dissolve in 4-8 oz (ounces) water/juice. Take with food/meal...

Review of the manufacturer's label for Potassium Chloride Solution revealed, "...MUST BE DILUTED..."

Review of the manufacturer's specification for Potassium Chloride in the Geriatric Dosage Handbook Sixteenth Edition pages 1437 and 1438, under "...Administration..." revealed, "...Oral dosage forms should be taken with meals..."

Interview with LPN #1 on January 9, 2012, at 10:09 a.m., at Medication Cart #2 outside resident rooms 23 and 24 in the New Side Front Hallway confirmed Resident #6 was not eating at the time the Potassium Chloride Solution was administered and the breakfast tray for Resident #6 was served on January 9, 2012, between 7:30 a.m., and 8:00 a.m. Further interview with LPN #1
F 332. Continued From page 6
confirmed one medication error occurred when
the Potassium Chloride was not diluted before
administration; was administered without food
and approximately one hour and forty minutes
after breakfast was served.

Interview with the Director of Nutritional Services
on January 10, 2012, at 10:20 a.m., in the MDS
office confirmed breakfast trays were served to
the residents beginning at 7:30 a.m., and lunch
trays were served to the residents beginning at
11:30 a.m., on January 9, 2012; and no other
meal trays were served between breakfast and
lunch.

Medication Error #4

Observation on January 9, 2012, at 9:44 a.m., at
Medication Cart #2, revealed LPN #1 crushed
one Suboxone (combination medication of 8 mg
Buprenorphine and 2 mg Naloxone) sublingual
(under the tongue) film for pain and handed the
dose to Resident #6. Resident #6 swallowed the
crushed film without placing it under the tongue.

Medical record review of the January 2012,
Recapitulation orders for Resident #6 revealed an
order for "SUBOXONE SUBLINGUAL
8MG/2MG TABLET...TAKE 1 TAB BY MOUTH
THREE TIMES DAILY...."

Review of the manufacturer's specification for
"...Method of Administration..." of Suboxone
sublingual revealed, "...The sublingual film must
be kept under the tongue until the film is
completely dissolved. SUBOXONE sublingual
film should NOT be chewed, swallowed, or
moved after placement...".
<table>
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<tr>
<th>ID</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 332</td>
<td>Continued From page 7</td>
<td>Interview with LPN #1 on January 9, 2012, at 10:09 a.m., at the Medication Cart #2 outside resident rooms 23 and 24 in the New Side Front Hallway confirmed a medication error occurred when the sublingual Suboxone film was crushed and administered by the incorrect route of swallowing.</td>
<td>F 332</td>
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<tr>
<td>F 428</td>
<td>483.60(c) Drug Regimen Review, Report Irregular, ACT ON</td>
<td>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</td>
<td>F 428</td>
<td></td>
<td>2/24/2012</td>
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</tbody>
</table>

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, the facility failed to ensure the physician responded timely to pharmacy recommendations for one resident (#11) of eighteen residents reviewed.

The findings included:

Resident #11 was admitted to the facility on November 30, 2011, with diagnoses including Dementia, Anxiety, and Psychosis.

Medical record review of a Pharmacy

[Other sections of the form with dates and completed actions]
LIFE CARE CENTER OF RHEA COUNTY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

F 428 Continued From page 8
Consultation Report dated December 13, 2011, revealed "...Recommendation: Please consider increasing Namenda (medication for dementia) to 10 mg (milligrams)...to twice daily as maintenance dose."

Continued medical record review revealed the physician had not responded to the recommendation.

Interview with the Director of Nursing on January 11, 2012, at 11:40 a.m., in the Social Services office, confirmed the facility delayed notifying the physician of the Pharmacy recommendation.

431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & 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.

F 426 How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place?

a) The Director of Nursing or Nursing Home Administrator will report the results monthly pharmacy recommendation audits to the performance improvement committee, which consists of the nursing home administrator, medical director, director of nursing, assistant director of nursing, staff development coordinator, pharmacy consultant, human resource director, social service director, rehab services manager, dietary manager, admission/marketing coordinator, business office manager, wound care nurse, housekeeping/launder director, activity coordinator, and health information manager, for three months.

b) The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.
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.

This REQUIREMENT is not met as evidenced by:
Based on observation, review of facility policy, review of Tennessee Pharmacy Laws 2011 Edition, and interview, the facility failed to assure the contents of emergency medications for residents were secured in one (Blue Intravenous [IV] Emergency Box) of nine emergency boxes observed.

The findings included:
Observation of the Blue IV Emergency Box on January 9, 2012, at 12:59 p.m., in the New Side Medication Room with Licensed Practical Nurse (LPN) #2 revealed the box was not locked.
Further review of the list of contents of the Blue IV Emergency Box revealed 23 intravenous solutions, including Dextrose 5% (per cent) with Water 1000 ml (milliliter) bag and Normal Saline 0.9% 1000 ml bag, were available for emergency use for residents.
Review of the facility policy, "Emergency Drug Box...Procedure..." revealed "...1. The head nurse or a designee checks the expiration date..." and the head nurse or a designee failed to complete the required checking the expiration date.

What corrective action will be taken to correct this alleged deficient practice?

- Emergency box was locked immediately.
- Licensed personnel were in-serviced by the staff development coordinator on 1/9/2012 and 2/20/2012 on proper procedure for locking emergency boxes.

Identify residents that have the potential to be affected by the alleged deficient practice.

- All emergency boxes were checked on 1/9/2012 to ensure they were locked properly. No other boxes were found unsecured.

What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur?

- Licensed personnel will be in-serviced by the staff development coordinator on 1/9/2012 and 1/26/2012 on proper procedure for locking emergency boxes.
- Licensed personnel will check all emergency boxes on a daily basis starting 1/11/2012.
- The Assistant Director of Nursing or Director of Nursing will audit emergency lock boxes for proper locking starting 1/20/2012 to 2/17/2012 weekly and monthly for 2 months.
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<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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| F 431 | Continued From page 10 and seal on the box on each shift...
Review of the Tennessee Pharmacy Laws 2011 Edition Rule 1140-4-.09 Emergency and Home Care Kits page 210 documented "...(3) The emergency kit shall be provided sealed or electronically secured by authorized personnel in accordance with established policies...

Interview with LPN #2 on January 9, 2012, at 1:20 p.m., in the New Side Medication Room, confirmed the Blue Intravenous Emergency Box was unlocked and the contents of the emergency box were not secured per facility policy. | F 431 | How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place?

a) The Director of Nursing or Nursing Home Administrator will report the results of monthly pharmacy recommendation audits to the performance improvement committee, which consist of the nursing home administrator, medical director, director of nursing, assistant director of nursing, staff development coordinator, pharmacy consultant, human resource director, social service director, rehab services manager, dietary manager, admission/marketing coordinator, business office manager, wound care nurse, housekeeping/laundry director, activity coordinator, and health information manager, for three months.

b) The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.
F 441 Continued From page 11

(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.

(c) 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 observation, facility policy review, and interview, the facility staff failed to maintain clean technique and wash the hands appropriately during a dressing change for two (#3, #8) of eighteen residents reviewed.

The findings included:
Observation on January 9, 2012, at 2:40 p.m., revealed Registered Nurse (RN) #1 providing wound care to resident #3. Observation revealed RN #1 removed a dressing from the resident's buttocks. Continued observation revealed RN #1 used a gauze pad to clean a wound on the right buttock with a scant amount of blood, and used the same gauze pad to clean an open wound on the left buttock. Continued observation revealed, without changing the gloves or washing the hands, RN #1 applied one large dressing to the wounds.

F 441
What corrective action will be taken to correct this alleged deficient practice?

a) RN #1 was educated by Director of Nursing and Staff Development Coordinator on infection control in relation to proper hand washing and usage of gloves on 1/9/2012 and 1/20/2012.

b) All personnel were in-serviced on infection control in relation to proper hand washing and usage of gloves by staff development coordinator on 1/9/2012 and 1/26/2012.

Identify residents that have the potential to be affected by the alleged deficient practice.

a) All facility residents have the potential to be affected.

b) Staff Development Coordinator completed a 100% observation on 1/26/2012 on infection control of all residents. No other residents were affected.
Review of the facility's policy Wound Care Procedure for Major Wounds revealed "...clean technique..." Clean the wound according to the order. Clean from the center outward... Place soaked gauze used for cleaning in the bag... Remove gloves...

Interview on January 9, 2012, at 2:55 p.m., with RN #1, in the hallway, revealed RN #1 described the wounds on the right and left buttocks as Stage II pressure ulcers measuring approximately 1.2 cm (centimeters) by 1.4 cm. Continued interview revealed each wound was to be cleaned with a separate gauze pad, and confirmed the hands were to be washed after cleansing a wound prior to applying a clean dressing.

Observation on January 9, 2012, at 2:00 p.m., revealed RN #1 providing wound care to resident #6. Observation revealed after completing wound care to resident #6, RN #1 removed the gloves and washed the hands. Continued observation revealed the following: RN #1 reapplied gloves and placed soaked linens into a plastic bag and picked up a bag with soaked dressings; placed the soaked linens into a laundry cart, and placed the bag with the soaked dressings into a biohazard storage box in the soiled utility room; removed the gloves and without washing the hands returned to resident #6's room and removed scissors from a drapery on the resident's table, unlocked the dressing cart, and obtained a bleach wipe to clean the scissors.

Review of the facility's policy Standard Precautions revealed "...the purpose is to reduce the risk of transmission of infection,

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<th>F 441</th>
<th>What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur?</th>
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<tbody>
<tr>
<td></td>
<td>a) All personnel were in-serviced on infection control in relation to proper hand washing and usage of gloves by Staff Development Coordinator on 1/9/2012 and 1/26/2012.</td>
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<td>b) Director of Nursing will conduct visual audits starting 1/19/2012 to 2/16/2012 and then monthly for two months on proper infection control process during wound care with wound care nurse.</td>
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<td>c) Nursing Home Administrator will audit the infection control process weekly for completion for four weeks and monthly for two months.</td>
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<tr>
<th>How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place?</th>
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<tr>
<td>a) The Director of Nursing or Nursing Home Administrator will report the results of infection control audits to the performance improvement committee, which consists of the nursing home administrator, medical director, director of nursing, assistant director of nursing, staff development coordinator, pharmacy consultant, human resource director, social service director, rehab services manager, dietary manager, admission/marketing coordinator, business office manager, wound care...</td>
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| F 441 | Continued From page 13
Standard precautions apply to all residents and in all situations. The required elements of standard precautions include: 1) adequate hand hygiene at all times...Follow hand hygiene recommendations immediately or as soon as feasible after removal of gloves...” Interview on January 9, 2012, at 2:25 p.m., with RN #1, in the hallway, confirmed the hands were not washed after placing the soiled linens into the laundry cart and the soiled dressing into the biohazard storage box, and removing the gloves, prior to reentering the resident’s room and unlocking the dressing cart to clean the soiled scissors. | F 441 | nurse, housekeeping/laundry director, activity coordinator, and health information manager, for three months. The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved |