**STAFF STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID PREFIX</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X6) COMPLETION DATE</th>
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| F 000     |     | **INITIAL COMMENTS**  
During the annual recertification survey conducted on August 30, 2010, through September 1, 2010, at Spring City Care and Rehabilitation, complaint #28070 was investigated and no deficiencies were cited in relation to the complaint under 42 CFR Part 483.13, Requirements for Long Term Care. | F 000     |     | **Disclaimer**  
Spring City Care and Rehabilitation Center does not believe and does not admit that any deficiencies exist, before, during and after the survey. Spring City Care and Rehabilitation Center reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceeding or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and Spring City Care and Rehabilitation Center reserves all right to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceedings. Nothing contained in this Plan of Correction should be considered as a waiver of any potential applicable Fees. **Pre-restraint assessment for resident #8 was completed on 9-13-2010 by the Assistant Director of Nursing.**  
1) Pre-restraining assessment for resident #8 was completed on 9-13-2010 by the Assistant Director of Nursing.  
2) Resident who require restraints have the potential to be affected. All residents utilizing restraints medical records were audited to ensure a pre-restraining assessment was completed. This audit was completed on 9-15-10 by restorative nurse.  
3) The policy and procedure for restraint utilization was reviewed on 9-13-10. Education was provided to the Restorative Nurse, QA nurse, Assistant Director of Nurses, and MDS Coordinators by the Director of Nursing on 9-14-10 regarding this policy and procedure. Pre-restraining assessment will be completed prior to restraint implementation. A review of | |
| F 221     |    | **483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS**  
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 and interview the facility failed to assess for a restraint for one (#8) of twenty-six residents reviewed.  
The findings include:  
Resident #8 was admitted to the facility on March 24, 2006, with diagnoses including Alzheimer's Disease, Renal & Ureteral Disease, Joint Effusion, Congestive Heart Failure, Kaschin Beck Disease, and Mental Disorder.  
Review of the Minimum Data Set dated July 21, 2010, revealed the resident had difficulty with long and short term memory, and severe difficulty with decision making skills. Continued review revealed the resident required assistance with all activities of daily living including feeding.  
Review of the Fall Risk Evaluation dated January | F 221     |    | **Disclaimer**  
Spring City Care and Rehabilitation Center does not believe and does not admit that any deficiencies exist, before, during and after the survey. Spring City Care and Rehabilitation Center reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceeding or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and Spring City Care and Rehabilitation Center reserves all right to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceedings. Nothing contained in this Plan of Correction should be considered as a waiver of any potential applicable Fees. **Pre-restraint assessment for resident #8 was completed on 9-13-2010 by the Assistant Director of Nursing.**  
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**LABORATORY DIRECTOR'S QA PROVIDERSUPPLIER REPRESENTATIVE'S SIGNATURE**

**TITLE**

9-15-10

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 those documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.
Continued From page 1
30, April 26, and August 8, 2010, revealed the resident was at high risk for falls.

Review of the facility documentation revealed the resident had a history of falls. Continued review of facility documentation revealed on March 3, 2010, at 11:00 a.m., the resident fell out of the wheelchair. Continued review of the facility documentation revealed a Self Releasing Alarming Seat Belt was applied, on March 3, 2010.

Interview with the Assistant Director of Nursing on August 31, 2010, at 3:30 p.m., in the conference room confirmed the resident was not able to release the seat belt restraint.

Interview with the Director of Nursing on September 1, 2010, at 10:30 a.m., in the conference room confirmed a self releasing alarming seat belt was applied on March 3, 2010, and a Pre-restraining Assessment was not completed prior to the belt being applied.

F 279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident’s comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident’s...
Continued From page 2:

highest practical physical, mental, and
psychosocial well-being as required under
§483.25, and any services that would otherwise
be required under §483.25 but are not provided
due to the resident's exercise of rights under
§483.10, including the right to refuse treatment
under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on medical record review, facility policy
review, and interview, the facility failed to revise
the care plan for one (#12) of twenty-six residents
reviewed.

The findings included:

Resident #12 was admitted to the facility on
November 11, 2008, with diagnoses including
Diabetes Mellitus, Peripheral Vascular Disease,
Lymphedema, Muscle Weakness, Congestive
Heart Failure, Cellulitis of Leg, Generalized Pain,
Atrial Fibrillation, Dehility, and Morbid Obesity.

Medical Record review of a Urine Culture and
Sensitivity (C&S) Laboratory Report dated August
19, 2010, revealed Methicillin Resistant
Staphylococcus Aureus of the urine. Continued
review of the Culture and Sensitive (C&S)
Laboratory Report dated August 19, 2010,
revealed Methicillin Resistant Staphylococcus
Aureus of a wound; and on August 23, 2010, the
laboratory report determined abundant growth of
Enterococcus Faecalis Group D of the wound.

Review of the facility policy for Isolation revealed:
"Contact Precautions - In addition to Standard
Precautions, implement Contact Precautions for
Residents who are on isolation
precautions have the potential to be affected.
MDS Coordinators completed a 100% audit
care plans with residents with need of
isolation to ensure care plans reflected the
need for contact isolation on 9/1/10. No
aberrations were noted.

3) The process of identification and
communication regarding laboratory
cultures was reviewed and revised by the
Director of Nursing, QA Nurse and
Assistant Director of Nursing on 9-14-10. It
was reviewed and approved by the Medical
Director on 9/15-10. Residents laboratory
cultures will be reviewed during the
morning clinical meeting by the clinical IDT
which includes the Director of Nursing, the
Assistant Director of Nursing, Restorative
Nurse Manager, MDS Coordinators, Social
Services, Activities Director, and Certified
Dietary Manager, Rehab Services Manager,
and the QA nurse, using the laboratory
culture report. The Assistant Director of
Nursing will in service the process change to
licensed staff by 9-24-10. The in service
will be mailed to licensed staff that was not
available during the time of in-service by 9-
25-2010. The nurse managers which
include the Assistant Director of Nursing,
the QA Nurse, the MDS Coordinators and
Restorative Nurse were in service regarding care plan updating to reflect the
need for isolation on 9/14/10 by the Director of Nursing.
F 279 Continued From page 3 residents known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment...

Interview with the Director of Nursing on August 30, 2010, at 4:10 p.m., in the conference room confirmed the resident's care plan was not updated to reflect the need for contact isolation of the resident.

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 the physicians orders for a medication allergy, and failed to obtain a physician's order for contact isolation, for one (#12) of twenty-six residents reviewed.

The findings included:
Resident #12 was admitted to the facility on November 11, 2008, with diagnoses including Diabetes Mellitus, Peripheral Vascular Disease, Lymphedema, Muscle Weakness, Congestive Heart Failure, Cellulitis of Leg, Generalized Pain, Atrial Fibrillation, Debility, and Morbid Obesity.

Review of the Minimum Data Set dated July 29,
F 281 Continued From page 4
2010, revealed the resident had no difficulty with long and short term memory, and no difficulty with decision making skills, and was non ambulatory.

Medical record review revealed a physician’s order dated August 26, 2010, for Vancomycin 500 mg. BID (two times a day) x one day. Continued medical record review revealed the resident had an allergy to Vancomycin.

Review of the Medication Administration Record for August 2010, revealed the resident received two doses of Vancomycin (Suspension) 500 mg. on August 30, 2010.

Interview with Licensed Practical Nurse (LPN #3, one of the LPN’s who administered the medication) on September 1, 2010, at 3:30 p.m., at the nurse’s station confirmed LPN #3 was unaware of the resident’s allergy to Vancomycin at the time it was administered.

Review of a faxed document from the pharmacist dated September 1, 2010, at 11:46 a.m., revealed, “Spoke with nurse regarding possible allergy to Vancomycin & cautioned about the need to observe for allergy signs & symptoms, and to have Benadryl/Epinephrine available if needed.”

Interview with the Director of Nursing on September 1, 2010, at 3:00 p.m., in the conference room confirmed the resident’s medical record indicated an allergy to Vancomycin and the resident was administered Vancomycin 500 mg. two times on August 30, 2010.

Continued medical record review of resident F 281
3) The process for identification of allergies was reviewed 9-2-10 by the Director of Nursing and QA Nurse. It was reviewed and approved by the Medical Director on 9-15-10. Changes will be made to this process to include allergies noted on an alert page in medical record and on the resident medication administration record by 9-24-10. The process of identification and communication regarding laboratory cultures was reviewed and revised by the Director of Nursing, QA Nurse and Assistant Director of Nursing on 9-14-10. It was reviewed and approved by the Medical Director on 9-15-10. Resident’s laboratory cultures will have allergies listed on the culture results prior to facility fixing the laboratory cultures to the physician. The laboratory cultures will be reviewed during the morning clinical meeting by the clinical IDT which includes the Director of Nursing, the Assistant Director of Nursing, Restorative Nurse Manager, MDS Coordinators, Social Services, Activities Director, and Certified Dietary Manager, Rehab Services Manager, and the QA nurse. The Assistant Director of Nursing in serviced this process change to licensed staff this in service also included the need for physician orders for isolation by 9-24-10. The in service will be mailed to licensed staffs that were not available during the time of in-service by 9-25-10. The nurse managers which include the Assistant Director of Nursing, the QA Nurse, the MDS Coordinators and Restorative Nurse were in-service regarding identification of allergies, laboratory cultures and physician orders for isolation was provided by the Director of Nursing on 9/14/10.
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<tr>
<td>F281</td>
<td>Continued From page 5 #12's laboratory reports for Urine and Wound Cultures dated August 19, 2010, revealed the resident was positive for Methicillin Resistant Staphylococcus Aureus of the Urine and Wound. Interview with the Director of Nursing (DON) on August 30, 2010, at 4:10 p.m., in the conference room, confirmed the resident was placed on Isolation Precautions on August 23, 2010, six days after the laboratory reports were received. Continued interview with the DON confirmed a physician's order was not obtained for &quot;isolation&quot; until August 30, 2010.</td>
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<td>F281</td>
<td>4) The Director of Nursing, the Assistant Director of Nursing, or the QA nurse will completed an 100% audit on laboratory cultures and residents on antibiotics, weekly for four weeks on an audit log to ensure physician orders for isolation are obtained if indicated and allergies are abided by. Aberrations will be corrected immediately. These audits will continue monthly for three months. These audit logs will be reviewed quarterly by the Quality Assurance Committee to include the Director of Nursing, the Assistant Director of Nursing, the QA nurse, the MDS Coordinators, the Restorative Nurse Manager, Treatment Nurse, Staff Development Coordinator, Administrator, Medical Director, Social Services and Activities Director for further recommendations.</td>
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<td>F315</td>
<td>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</td>
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<td>F315</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. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to complete an accurate bladder assessment and develop a bladder retraining/management program for one (#21) of twenty-six residents reviewed. The findings included: Resident #21 was admitted to the facility on</td>
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<tr>
<td>F315</td>
<td>1) Resident #21 bladder assessment was completed by the RN on 9/13/10 with referral to bladder program.</td>
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<td>F315</td>
<td>2) 100% of all bladder assessments were completed by restorative nurse on 9-16-10. Aberrations were corrected immediately.</td>
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<tr>
<td>F315</td>
<td>3) In service was provided to the Restorative Nurse Manager on 9/11/10 regarding completion of an accurate bladder retraining/management program by the Director of Nursing. The bladder assessment policy and the bladder training programs were reviewed on 9-13-10. Restorative Nurse Manager will complete a Restorative Nurse Manager skills competency checklist by 9/24/10. This skills checklist will be conducted annually under the supervision of</td>
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October 3, 2009, with diagnoses including Hypertension, Vascular Dementia, and Dysphagia.

Medical record review of the Minimum Data Set dated June 14, 2010, revealed the resident was frequently incontinent of bladder.

Medical record review of the Bladder Evaluation dated July 28, 2010, revealed the resident was continent of bladder with staff assist, and the resident was provided with beige colored briefs.

Medical record review of the July 1-31, 2010, CNA (Certified Nursing Assistant) ADL Tracking Form revealed the resident had multiple daily episodes of bladder incontinence.

Observation on September 1, 2010, at 8:40 a.m., revealed the resident lying on the bed. Interview with the resident, at the time of the observation, revealed the resident recognized the urge to void.

Interview on September 1, 2010, at 9:10 a.m., with CNA #1 (CNA responsible for the resident's care), at the nursing station, revealed the resident was incontinent daily.

Review of the facility's policy Bowel & Bladder Incontinence Management revealed "Residents admitted incontinent or who become incontinent will be evaluated for bowel or bladder incontinence management...as appropriate. The goal of this program is to promote continence...to the greatest extent possible while increasing independence and dignity of the resident..."

Interview on September 1, 2010, at 8:45 a.m., with Registered Nurse (RN) #3 (nurse who the Director of Nurses and or the Assistant Director of Nursing. Bladder assessments will be reviewed for accuracy during the resident care conference quarterly or with a significant change by the IDT which includes the Director of Nursing, the Assistant Director of Nursing, Restorative Nurse Manager, MDS Coordinators, Social Services, Activities Director, and Certified Dietary Manager, Rehab Services Manager, and the QA nurse using an audit tool.

4) An audit log will be completed on resident medical records weekly for four weeks, by either the Director of Nursing, the Assistant Director of Nursing, the MDS Coordinators, the Restorative Nurse Manager, Treatment Nurse and/or Staff Development nurse to assure accurate bladder assessments and development of a bladder retraining/management program. Aberrations will be corrected immediately. These audits will continue monthly for three months. These audit logs will be reviewed quarterly by the QA committee to include the nurse managers the Director of Nursing, the Assistant Director of Nursing, the MDS Coordinators, the Restorative Nurse Manager, Treatment Nurse and Staff Development nurse, Administrator, Medical Director, Social Services and Activities Director for further recommendations.
F 315  
Completed From page 7  

Continued the Bladder Evaluation dated July 28, 2010, at the nursing station, revealed RN #3 had not reviewed the July 2010, CNA (Certified Nursing Assistant) ADL Tracking Form and confirmed the Bladder Evaluation was not accurate and a bladder retraining program had not been established for the resident.

F 323 483.25(n) FREE OF ACCIDENT  
HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:  
Based on medical record review, observation, and interview, the facility failed to ensure adequate assistance with toileting and failed to ensure a safety device was in place for one (#6), and failed to provide adequate assistance with transfers for one (#15) of twenty-six residents reviewed.

The findings included:

Resident #6 was admitted to the facility on December 30, 2009, with diagnoses including Fractured Hip, Hypertension, Pneumonia, and Diabetes.

Medical record review of the Minimum Data Set (MDS) dated March 21, 2010, revealed the resident had short term memory problems, was

F 323

1) Resident #6 was reassessed by the Assistant Director of Nurses for the continued need of the alarms on 9/14/10. The Care Plan was updated to reflect the changes made. C.N.A #2 was educated on providing adequate assistance with transfers for resident #15.

2) All residents have the potential to be affected by this practice.

3) The process of identification and communication regarding alarms was reviewed and revised by the Director of Nursing, Assistant Director of Nursing, second shift C.N.A mentor and Restorative Nurse Manager on 9-13-10. It was reviewed and approved by the Medical Director on 9-15-10. Residents at risk for falls with intervention of alarms will be documented on a shift change report sheet to be completed via walking rounds with on coming and off going staff. The Restorative nurse, the Director of Nursing, and Assistant Director of Nursing developed a fall alert identification system to assist with the identification of residents at risk for falls needed on 9-2-10. The Restorative Nurse and the Assistant Director of Nurse in served this process change to facility staff by 9-24-10. The in service will be mailed to employee’s who were not available during the time of initial in-service by 9-25-10.
F 323

Continued From page 8

totally dependent for toilet use, required extensive
assistance with transfers, and had fallen in the
past thirty days.

Medical record review of the Fall Risk Evaluations
dated January 30, 2010, and July 31, 2010,
revealed the resident was at high risk for falls.

Medical record review of the Resident Care Plan
dated March 24, 2010, revealed "...Potential for
falls...assist with all transfers...assist with toileting
needs..."

Medical record review of a nursing note dated
May 28, 2010, revealed "Resident was on toilet
CNA (Certified Nursing Assistant) left resident to
get a brief & (and) resident tried to get up and fell
on buttocks. Abrasions noted on Rt (right) (lower)
left, Rt mid back & Lt (left) lower buttocks..."

Medical record review of the Resident Care Plan
dated June 14, 2010, revealed "...Potential for
falls...Bed & chair tab alarm..." 

Observation on August 30, 2010, at 2:55 p.m.,
and 4:30 p.m., revealed the resident in the
wheelchair in the hallway without a tab alarm in
place. Observation and interview on August 30,
2010, at 4:35 p.m., with Registered Nurse (RN)
#2, revealed the resident sitting in the wheelchair,
in the hallway, and confirmed the tab alarm was
not in place.

Observation and interview on August 31, 2010, at
8:20 a.m., with Licensed Practical Nurse (LPN)
#1, revealed the resident lying on the bed, and
confirmed the tab alarm was not attached to the
resident.

4) An audit log will be completed on
residents with interventions to minimize the
risk of falls weekly for four weeks. These
audits will be done by either the Director of
Nursing, the Assistant Director of Nursing,
the MDS Coordinators, the Restorative
Nurse Manager, Treatment Nurse and/or
Staff Development nurse to ensure residents
with interventions are in place. Aberrations
will be corrected immediately. These audit
logs will continue monthly for three months.
These audit logs will be reviewed quarterly
by the QA to include the nurse managers the
Director of Nursing, the Assistant Director
of Nursing, the MDS Coordinators, the
Restorative Nurse Manager, Treatment
Nurse, and Staff Development nurse,
Administrator, Medical Director, Social
Services and Activities Director for further
recommendations.

9-09-10
F 323
Continued From page 9

Interview on August 31, 2010, at 10:30 a.m., with the Assistant Director of Nursing, in the conference room, confirmed the resident was totally dependent with toileting, had short term memory problems, required extensive assistance with transfers, at the time of the fall on May 28, 2010. Continued interview confirmed the resident was unattended at the time of the fall on May 28, 2010.

Resident #15 was admitted to the facility on August 3, 2010, with diagnoses including Spinal Stenosis, Lumbar, Muscle Weakness, Difficulty Walking, Dehility, Hypertension, Diabetes Mellitus II, Osteoporosis, Depression Disorder, Renal Failure, had a History of Cerebrovascular Accident, and had a history of falls during the previous hospitalization.

Review of the Minimum Data Set dated August 15, 2010, revealed the resident had difficulty with long and short term memory; no difficulty with decision making skills; and received extensive assist of two staff with transfers and ambulation.

Review of facility documentation dated August 28, 2010, at 3:10 p.m., revealed, "While (the resident) was standing and (CNA) was putting (the resident's) brief on, (the resident) started to fall. (The CNA) braced (the resident) from behind and (the resident) bumped his/her head against the wall. (The CNA) helped (the resident) to the floor and sent for 600 Hall nurse..." Continued review of facility documentation revealed the shower room floor was wet, and the resident slid on the wet floor.

Continued review of the facility documentation revealed the resident was sent to the emergency
**SPRING CITY CARE AND REHABILITATION CENTER**

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<td>F 323</td>
<td>Continued From page 10 room for evaluation and x-ray of the right hip, which was negative for fracture. Review of the Certified Nursing Assistant's plan of care for the resident revealed, &quot;... Assist of 2 staff for Mobility...&quot;. Interview with Certified Nursing (CNA # 2) on September 1, 2010, at 1:30 p.m., by phone confirmed the resident was being assisted by one CNA with standing, transfer, and applying the brief following a shower, when the resident fell. Interview with Licensed Practical Nurse (LPN #5), and (#6), on September 1, 2010, at 9:30 a.m., at the nursing station, confirmed the resident was a two person assist with transfers, and only one CNA was present during the time of the fall.</td>
<td>F 323</td>
<td>F- 332 notified the physician and responsible party that metoclopramide was not given prior to breakfast. LPN #4 notified physician and responsible party that the dose and type of ASA and the dose of Minoxidil that was given is error. 2) All resident have the potential to be affected by this practice. 3) A review of the medication pass times was completed by the Director of Nursing and Assistant Director of Nursing on 9-13-10. Medication times were adapted with the approval of the Medical Director on 9-15-10. The Director of Nurses and/or the Assistant Director of Nurse in served this process change to licensed nursing staff by 9-24-10. The in service will be mailed to employee's who were not available during the time in-service by 9-25-10. License nurse will completed skills checklist regarding the 5 rights of medication pass by 9-24-10. This skill checklist will be completed during new hire orientation of licensed nurses and licensed staff will be required to complete this skill checklist annually.</td>
<td>09/01/2010</td>
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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 medical record review, observation, and interview, the facility staff failed to appropriately administer medications in three of fifty-one opportunities, resulting in a 5% medication error rate.

The findings included:

Medical record review of resident #21's physician's recapitulation orders, dated August 2010, revealed "... Metoclopramide 5 mg..."
| F 332 Continued From page 11 (milligrams) give 1 tablet by mouth before meals and at bedtime. DX: (diagnosis) nausea. |
| F 332 Observation on August 31, 2010, at 6:05 a.m., revealed Licensed Practical Nurse (LPN) #2 administered Metoclopramide 5 mg to the resident. Continued observation revealed the resident was completing the breakfast meal |
| F 332 Interview on August 31, 2010, at 8:10 a.m., with LPN #2, in the hallway, confirmed the Metoclopramide was not administered before breakfast |
| F 332 During observation of the medication pass on August 31, 2010, at 8:10 a.m., on the 500 hall revealed Licensed Practical Nurse (LPN #4), administered Aspirin 325 mg. (Milligrams) 2 tabs (not Enteric Coated) by mouth to resident #25. Continued observation revealed LPN #4 administered ½ capful of Miralax (approximately 8.5 grams) mixed in water to resident #25 |
| F 332 Interview with LPN #4 and the Director of Nursing, on August 31, 2010, at 10:45 a.m., at the nursing station, confirmed the wrong dose and type of Aspirin was administered and the resident received approximately ½ dose of Miralax. |

4) An Medication audit log will be completed randomly during medication pass on the licensed nurses weekly by the Director of Nurses and/or QA nurse, Assistant Director of Nursing and/or pharmacy consultant during medication pass to ensure the medication pass is completed per policy. Aberrations will be corrected immediately. These audits will continue monthly for three months. These audit tools will be reviewed quarterly by the QA to include the nurse managers the Director of Nursing, the Assistant Director of Nursing, the MDS Coordinators, the Restorative Nurse Manager, Treatment Nurse, and Staff Development nurse, Administrator, Medical Director, Social Services and Activities Director for further recommendations.
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| F 333         | Continued From page 12  
The facility must ensure that residents are free of any significant medication errors.  

This REQUIREMENT is not met as evidenced by:  
Based on medical record review, observation, and interview, the facility failed to ensure a resident was free of significant medication errors by receiving medications the resident was allergic to for one (#12) of twenty-six residents reviewed.  

The findings included:  
Resident #12 was admitted to the facility on November 11, 2008, with diagnoses including Diabetes Mellitus, Peripheral Vascular Disease, Lymphedema, Muscular Weakness, Congestive Heart Failure, Cellulitis of Leg, Generalized Pain, Atrial Fibrillation, Deblity, and Morbid Obesity.  

Review of the Minimum Data Set dated July 29, 2010, revealed the resident had no difficulty with long and short term memory, and no difficulty with decision making skills, and was non ambulatory.  

Medical record review revealed a physician's order dated August 28, 2010, for Vancomycin 500 mg. BID (two times a day) x one day. Continued medical record review revealed the resident had an allergy to Vancomycin.  

Review of the Medication Administration Record for August 2010, revealed the resident received two doses of Vancomycin (Suspension) 500 mg. on August 30, 2010.  

Interview with Licensed Practical Nurse (LPN #3) of the LPN's who administered the

**F-333**  
1) Resident #12 received two dose of Vancomycin without incident. Physician and responsible party were notified on 8-31-10 by the QA nurse.  

2) Resident receiving antibiotics have the potential to be affected. 100% audit was completed by the Director of Nursing for residents on antibiotics to ensure ordered antibiotics were devoid of known allergies. No aberrances were noted. This audit was completed on 9/13/10.  

3) The process for identification of allergies was reviewed on 9-3-10. Changes were made to this process to include allergies noted on an alert page in medical record and on the resident medication administration record. It was reviewed and approved by the Medical Director on 9-15-10. The Assistant Director of Nursing will in services this process change on licensed staff by 9-24-10. The in service will be mailed to licensed staff that was not available during the time of the In-service by 9-25-10. The nurse managers which include the Assistant Director of Nursing, the QA Nurse, the MDS Coordinators and Restorative Nurse were in services regarding identification of allergies and laboratory cultures was provided by the Director of Nursing on 9/14/10.  

4) The Director of Nursing, the Assistant Director of Nursing, or the QA nurse will complete a 100% audit on allergy identification using an audit tool, weekly for four weeks to ensure allergies are abided by.
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<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 333</td>
<td>Continued From page 13 medication) on September 1, 2010, at 3:30 p.m., at the nurse's station confirmed LPN #3 was unaware of the resident's allergy to Vancomycin at the time it was administered. Review of a faxed document from the pharmacist, dated September 1, 2010, at 11:48 a.m., revealed, &quot;Spoke with nurse regarding possible allergy to Vancomycin &amp; cautioned about the need to observe for allergy signs &amp; symptoms, and to have Benadryl/Epinephrine available if needed.&quot; Interview with the Director of Nursing on September 1, 2010, at 3:00 p.m., in the conference room confirmed the resident's medical record indicated an allergy to Vancomycin and the resident was administered Vancomycin 500 mg. two times on August 30, 2010.</td>
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<tr>
<td>F 425</td>
<td>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</td>
<td>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 the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation</td>
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<td>F 333</td>
<td>Aberrances will be corrected immediately. These audits will continue monthly for three months. These audit tools will be reviewed quarterly by the Quality Assurance Committee to include the Director of Nursing, the Assistant Director of Nursing, the QA nurse, the MDS Coordinators, the Restorative Nurse Manager, Treatment Nurse, Staff Development Coordinator, Administrator, Medical Director, Social Services and Activities Director for further recommendations.</td>
<td>9-29-10</td>
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<tr>
<td>F 425</td>
<td>1) Pharmacy was contacted on 8/30/10 regarding delivery of medications.&lt;br&gt;2) All residents who receive medications from this pharmacy have the potential to be affected.&lt;br&gt;3) Pharmacy adapted hours of operation to extend hours on 9-13-10. A log was developed by Administrator and Director of Nursing to track delivery of medications on 9-1-10. All medications orders are not only faxed but orders are also called into the pharmacy to ensure timely delivery. The Assistant Director of Nursing will in service the process change to licensed staff by 9-24-10. The in service will be mailed to licensed staff that was not available during the time of the in-service by 9-25-10.</td>
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<td>(X4) ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID PREFIX TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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<tr>
<td>F 425</td>
<td>Continued From page 14 on all aspects of the provision of pharmacy services in the facility.</td>
<td>F 425</td>
<td>4) The Director of Nursing, the Assistant Director of Nursing, or the QA nurse will completed random audits via an audit log on timely medication deliver weekly for four weeks. Aberrances will be corrected immediately. These audits will continue monthly for three months. Those audit logs will be reviewed quarterly by the Quality Assurance Committee to include the Director of Nursing, the Assistant Director of Nursing, the QA nurse, the MDS Coordinators, the Restorative Nurse Manager, Treatment Nurse, Staff Development Coordinator, Administrator, Medical Director, Social Services and Activities Director for further recommendations.</td>
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</table>

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

Based on medical record review, review of the Pharmaceuticals Shipping Manifest, and interview, the facility failed to obtain medication for one (#12) of twenty-six residents reviewed.

The findings included:

Resident #12 was admitted to the facility on November 11, 2008, with diagnoses including Diabetes Mellitus, Peripheral Vascular Disease, Lymphedema, Muscle Weakness, Congestive Heart Failure, Cellulitis of Leg, Generalized Pain, Atrial Fibrillation, Debility, and Morbid Obesity.

Medical record review revealed a physician's order dated August 28, 2010, for Vancomycin (Antibiotic) 500 mg. (Milligrams) BID (two times a day) x (times) one day, which was faxed to the Pharmacy the same day. Review of the Pharmaceuticals Shipping Manifest revealed the Vancomycin was not received at the facility until August 30, 2010, at 6:00 a.m. Continued review of the Medication Administration Record revealed the resident received the first (of the two doses) on August 30, 2010, at 7:00 a.m..

Interview with the Director of Nursing on September 1, 2010, at 4:00 p.m., in the conference room, confirmed the resident did not receive the medication in a timely manner.
**SPRING CITY CARE AND REHABILITATION CENTER**

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<th>ID Prefix</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID Prefix</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>F 441</td>
<td>SS-D</td>
<td>Continued from page 15</td>
<td>F 441</td>
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<td>SPREAD, LINENS</td>
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<td>1) RN # 1 was immediately in serviced regarding hand washing by the Director of Nursing on 8/30/10. Isolation signage was place on resident's #12's door on 8/30/10 by the Director of Nurses.</td>
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<td>2) Residents who require isolation have the potential to be affected. 100% audit was completed by the Director of Nursing on all residents with isolation orders to ensure signage was place. No abberances were noted. This audit was completed on 9/13/10.</td>
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<td>3) The policy and procedure for hand washing and isolation signage was reviewed by the Director of Nursing, QA Nurse and Assistant Director of Nursing on 8-30-10. It was reviewed and approved by the Medical Director on 9-15-10. The physician orders for isolation will be reviewed during the morning clinical meeting and the Director of Nursing, QA nurse, Assistant Director of Nursing and or the MDS Coordinators will ensure signage is posted. The Assistant Director of Nursing will in serviced this process and the facility hand washing policy to the nursing staff by 9-24-10. The service will be mailed to nursing staff that were not available during the time of the in-service by 9-25-10.</td>
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(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.
F 441 Continued From page 16
This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, facility policy review, and interview, the facility staff failed to change the gloves and wash the hands during a dressing change for one (#4) and failed to place isolation signage for isolation notification for one (#12) of twenty-six residents reviewed.

The findings included:

Resident #4 was admitted to the facility on July 28, 2008, with diagnoses including Diabetes, Late Effects of Acute Polio, and Paraplegia.

Medical record review of a physician's note dated August 17, 2010, revealed "...L (left) leg lesion-is skin ca (cancer)... & (and)... declines tx (treatment) or surgical consult...buttock-Stage II..."

Observation on August 30, 2010, at 11:20 a.m., revealed Registered Nurse (RN) #1 providing wound care to resident #4. Observation revealed RN #1 removed a dressing from the left buttock, and without changing the gloves, cleaned the wound and described the wound as a Stage II pressure ulcer with a minimal amount of serous drainage. Continued observation revealed RN #1 removed the soiled gloves, washed the hands, applied clean gloves, and applied ointment with a clean dressing to the wound. Continued observation revealed RN #1 removed the soiled gloves, washed the hands, applied clean gloves and removed a dressing from the anterior left lower extremity. Continued observation revealed RN #1 described the drainage from the left lower extremity wound/lesion as a moderate amount of...
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<th>(X5) COMPLETION DATE</th>
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<tr>
<td>F 441</td>
<td>Continued From page 17 serous/brownish colored drainage. Continued observation revealed without changing the gloves, RN #1 cleansed the wound with normal saline. Continued observation revealed RN #1 removed the soiled gloves, and without washing the hands, applied clean gloves, and applied ointment and a dressing to the wound. Review of the facility's policy Dressing Procedures-Clean Technique revealed &quot;...Always change gloves after removing soiled dressing(s)...&quot; Review of the facility's policy Handwashing/Hand Hygiene revealed &quot;This facility considers hand hygiene the primary means to prevent the spread of infections...Employees must wash their hands...after removing gloves...&quot; Interview on August 30, 2010, at 3:30 p.m., with RN #1, in the Director of Nursing's office, confirmed the gloves were not changed after removing the soiled dressings from the left buttock. Continued interview confirmed after removing the dressing from the left lower extremity the gloves were not changed prior to cleaning the wound. Continued interview confirmed after cleaning the wound on the left lower extremity, the soiled gloves were removed, and the hands were not washed prior to applying clean gloves, and applying ointment and a dressing to the wound on the left lower extremity. Resident #12 was admitted to the facility on November 11, 2008, with diagnoses including Diabetes Mellitus, Peripheral Vascular Disease Lymphedema, Muscles Weakness, Congestive Heart Failure, Cellulitis of Leg, Generalized Pain,</td>
<td>F 441</td>
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SPRING CITY CARE AND REHABILITATION CENTER

331 HINCH STREET
SPRING CITY, TN 37381
F 441 Continued From page 18
Atrial Fibrillation, Debility, and Morbid Obesity.

Observation on August 30, 2010, at 9:10 a.m., revealed an over bed table placed on the outside of the resident's door, with a box of gloves, alcohol pads, and a package of yellow, disposable gowns. Continued observation revealed no signage on the resident's door revealing the need for isolation supplies.


Interview with Licensed Practical Nurse LPN #3 on August 30, 2010, at 9:10 a.m., in the hall near the resident's room, confirmed the resident had an infectious process but unsure what kind.

Review of the Isolation Policy revealed for contact isolation, signs used to alert staff of contact precautions—"Signs. use color coded signs or other measures to alert staff of implementation of transmission based precautions, while respecting the privacy of the resident...Orange is the color for contact precautions...at the door way, on head of bed, and front of resident's chart..."

Interview with the Director of Nursing on August 30, 2010, at 4:10 p.m., in the conference room confirmed the resident had Methicillin Resistant Staphylococcus Aureus of the urine and of a
Continued From page 19

wound (on the resident's buttocks) confirmed by laboratory reports received on August 19, 2010. Continued interview with the DON confirmed no signage had been placed on the resident's door, on the head of the bed, or on the resident's chart to alert the staff and/or visitors.