The annual recertification survey was conducted on October 17 - 19, 2011, at Northside Health Care Center.

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an incident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

The facility must notify the family/legal representative and the physician in changes with the patient.

Corrective Action
1. Physician was notified of the elevated blood sugar on 10/17/11 by the ADON.
2. Charts were audited on 10/19 thru 10/20 by DON and ADON to ensure other patients were not being affected by this practice.
3. DON and ADON in-services nursing staff on December 11 during a special licensed nursing meeting.
4. DON, ADON and the assistant supervisor will monitor for compliance during daily chart audits by reviewing new physician orders and ensuring will record results on audit tool. 100% will be audited for 30 days and uncorrected deficiencies will not be reported to the QA Committee. 100% will be audited for 30 days and uncorrected deficiencies will not be reported to the QA Committee. 100% will be audited for 30 days and uncorrected deficiencies will not be reported to the QA Committee.
5. Findings will be reported to the QA Committee who will review findings and set new interventions and goals as needed. The QA Committee consists of Medical Director, Administrator, DON, ADON, RN, Social Service, Food Service, Social Service, Food Service, Social Service, Food Service, Social Service, Food Service, Social Service, Food Service, Social Service, Food Service, Social Service, Food Service.
**F 157** Continued From page 1

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, the facility failed to notify the physician of abnormal blood glucose results for one (#9) of twenty residents reviewed.

The findings included:

Medical record review revealed resident #9 was admitted to the facility on October 14, 2011, with diagnoses to include Respiratory Failure, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Chronic Renal Failure, Congestive Heart Failure, Obstructive Sleep Apnea, and Dementia.

Review of admission orders dated October 14, 2011 revealed the resident was ordered sliding scale insulin and for a blood sugar greater than 401, to call the physician.

Review of nursing notes dated October 17, 2011 at 7:45 p.m., revealed "Reck (rechecked) BS (blood sugar) 458". Continued review revealed no documentation the physician had been notified of the blood sugar remaining above 401 as ordered upon admission.

Interview with the Director of Nursing (DON) and Assistant DON on October 17, 2011, at 10:40 a.m., in the nursing station, confirmed there was no documentation the physician had been notified of the resident's blood sugar above 401 and confirmed there was an order to notify the physician if blood sugar greater than 401.

**F 160**

483.10(c)(6) CONVEYANCE OF PERSONAL
F 160  Continued From page 2  
SS=D  FUNDS UPON DEATH

Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and all accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, the facility failed to convey the balance of an expired resident's fund account to the resident's estate within the thirty day time requirement for one resident (#18) of twenty residents reviewed.

The findings included:
Medical record review revealed the resident (#18) was admitted to the facility July 7, 2003 with diagnoses including Diabetes Mellitus, Hypertension, Renal Failure, Congestive Heart Failure, and Stroke.

Medical record review of the Discharge Summary dated April 3, 2011, revealed the resident expired at the facility on April 3, 2011.

Review of the resident funds ledger revealed the balance of the resident's account was returned to the resident's estate on May 20, 2011. Further review of the ledger revealed a deposit of $448.00 was credited to the resident's account on June 27, 2011 and remained in the account when reviewed on October 19, 2011.

Description
The facility will convey the balance of an expired resident's fund account to the resident's estate within the 30 day time requirement.

Corrective Action
1. Upon review, the money in the patient trust fund for resident #18 was issued by social security in error and was refunded to social security by check on 11/3/11 by administrative staff.
2. Review of the patient trust account was conducted by bookkeeping on 10/19/11 to ensure funds had been refunded to resident estates within the 30 day allotted time.
3. Administrative staff to include bookkeeping and payroll were re-instructed on 10/19/11 regarding refunding of patient trust account funds within 30 days.
4. Bookkeeping and Administrator will audit for compliance during random audits and monthly close-outs.
5. Findings will be reported to the QA Committee who will review and set new interventions and goals as needed. The QA Committee consists of the Medical Director, Administrator, DON, ADON, MDS Coordinator, Medical Records, Dietary, RD, Social Services, Bookkeeper, Payroll, Maintenance and Environmental Services.

11/3/11
Continued From page 3

Interview with the bookkeeper, in the bookkeeper's office, on October 19, 2011, at 10:30 a.m., confirmed the resident had expired April 3, 2011, the account balance of $448.00 was a direct deposit from the resident's pension on June 27, 2011 and the balance had not yet been returned to the estate.

F 164
483.10(e), 483.75(f)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS

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 telephonic communications, personal care, visits and meetings of family and resident group, 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 health care institution; law; third party payment contract; or the resident.

Description
The facility will provide privacy during medical care.

Corrective Action
1. EPN # 3 was given one on one counseling by the DON on 10/18/11 regarding providing privacy to the patient during care.
2. Nursing staff was in-services on 11/2/11 by Administrator and DON regarding privacy during patient care.
3. DON, ADON and Weekend Supervisor will audit for compliance during monthly med pass audits and during daily walking rounds.
4. Findings will be reported to the QA Committee who will review and set new interventions or goals as needed. The QA Committee consist of Medical Director, Administrator, DON, ADON, MDS Coordinator, Medical Records, Social, Activities, Food Service Supervisor, RD, Bookkeeping, Payroll, Maintenance and Environmental Services.
F 164 Continued From page 4

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to maintain privacy during medical care for one resident (ID 9) of twenty residents reviewed.

The findings included:
Resident #9 was admitted to the facility on October 14, 2011, with diagnoses of Diabetes, Respiratory Failure, Chronic Obstructive Pulmonary Disease, Chronic Renal Failure, Dementia, Congestive Heart Failure and Obstructive Sleep Apnea.

Observation on October 18, 2011, at 8:45 p.m., in the resident's room, revealed Licensed Practical Nurse (LPN) #3 administering a subcutaneous injection to the abdominal region of the resident, exposing the resident's abdomen and lower chest without closing the door or pulling the privacy curtains. Further observation revealed the room-mate was in the room eating dinner and staff were outside the open door passing dinner trays in the hallway.

Interview with LPN #3 on October 18, 2011 at 5:50 p.m., in the hallway outside the resident's room, confirmed privacy was not maintained during the injection.

F 253 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.
This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation of the wheelchair cleaning schedule and interviews, the facility failed to maintain resident care equipment in a sanitary manner for one resident (#7) of twenty residents reviewed.

The findings included:

Resident #7 was admitted to the facility on December 1, 2007 with diagnosis of Alzheimer's Disease, Atrial Fibrillation, Degenerative Disc Disease, Arthritis, Hypertension, and Failure to Thrive.

Medical record review of the Minimum Data Set dated August 16, 2011, revealed the resident had short and long term memory problems, impaired decision making, was dependent upon a wheelchair for mobility.

Observation on October 17, 2011, at 10:20 a.m., in the resident’s room, revealed a wheelchair with cloth like material affixed to the arm rests with paper tape. Numerous yellow and dark brown stains were noted on the material. Further observation revealed a white chair pad lying in the seat of the wheelchair with light yellow and light brown stains and a pair of shoes sitting atop the pad.

Review of facility document Wheel Chair/Geri Chair/Broda Chair Cleaning Schedule revealed the resident’s wheelchair was to have been cleaned on Saturday, October 15, 2011.

Corrective Action

1. Armrests were changed on the wheelchair for resident #7 by the Maintenance Supervisor and shoes and pad were removed from wheelchair on 10/17/11.
2. Facility rounds were made by DON and ADON on 10/17/11 to make sure wheelchairs were clean.
3. Staff was informed on 11/2/11 regarding maintenance of all wheelchairs and cleaning schedule.
4. DON and ADON will monitor for compliance during daily walking rounds.
5. Findings will be reported to the QA Committee who will review and set new interventions and goals as needed. The QA Committee consists of the Medical Director, Administrator, DON, ADON, MDS Coordinator, Medical Records, Social, Activities, Food Service Supervisor, RD, Bookkeeping, Payroll, Maintenance and Environmental Services.

11/2/11
Continued From page 6

Interview with Certified Nursing Assistant (CNA) #1 on October 17, 2011, at 10:24 a.m., in the hallway outside the resident's room, confirmed the wheelchair belonged to the resident, the seat pad and arm rests of the wheelchair were soiled, the shoes were not to be placed in the wheelchair seat, and it was unknown when the wheelchair was last cleaned.

**F 281**

483.20(k)(3)(i) SERVICES PROVIDE 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 follow physician's orders for administration of medications for two (#9, #9) of twenty residents reviewed.

The findings included:

Medical record review revealed resident #9 was admitted to the facility on March 7, 2011, and readmitted on August 25, 2011, with diagnoses to include Hypertension, Macular Degeneration, Glaucoma, Dementia, and repair of Hip Fracture.

Review of physician's admission orders revealed an order for Calcium Carbonate (TUMS) 1000 mg (milligrams) every 4 hours for digestion, and MVI (Multivitamins) 1 tablet daily.

Review of the Medication Administration Record (MAR) for August, September, and October 2011,
F 281 Continued From page 7
revealed the MVI tablet appeared each month on
the MAR but was documented as being
discontinued on August 17, 2011, and was not
administered. Review of physician’s orders dated
October 6, 2011, revealed “D/C (discontinue)
stress formula tab and Multi-T&M tab 3/4 (due to)
rec’g (receiving) One daily MVI tab”.

Review of the MAR for August, September, and
October, 2011, revealed the Calcium Antacid
(TUMS) was documented as being given pm (as
needed) with a note to “See pm sheet”.
Continued review of the MARs revealed there
was no documentation the resident received the
TUMS every four hours as ordered by the
physician.

Review of the physician’s recapitulation orders for
October 1 - 31, 2011, revealed “Calcium Antacid
500 mg chew, 2 every 4 hours and as needed”.
Continued review of these orders revealed this
medication was yellowed out, indicating
 discontinuation of the medication, and a
hand-written entry was made of “TUMS 2 Q4h
(every 4 hours) as needed” but no scheduled
doses. Review of physician’s orders from August
through current date revealed no physician’s
orders to change the TUMS from every 4 hours
and pm to just pm.

Medical record review revealed resident #9 was
admitted to the facility on October 14, 2011, with
diagnoses to include Respiratory Failure,
Diabetes Mellitus, Chronic Obstructive Pulmonary
Disease, Chronic Renal Failure, Congestive
Heart Failure, Obstructive Sleep Apnea, and
Dementia.
<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>
</tr>
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<tbody>
<tr>
<td>F 281</td>
<td>Continued From page 8</td>
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</table>

Review of admission orders dated October 14, 2011, revealed the resident was ordered sliding scale insulin:
- Blood sugar 201 - 250 give 2 units insulin
- Blood sugar 251 - 300 give 4 units insulin
- Blood sugar 301 - 350 give 6 units insulin
- Blood sugar 351 - 400 give 8 units insulin
- Blood sugar > (greater than) 40 call physician

Review of Medication Administration Record (MAR) dated October 15, 2011, at 11:30 a.m., revealed the resident had a blood sugar of 495 and received 8 units of insulin; and at 5:00 p.m., the blood sugar was 453 and the resident received 8 units of insulin. Continued review revealed the physician was notified after the insulins were given instead of calling when the blood sugar was determined to be greater than 401.

Review of MAR dated October 16, 2011, at 11:30 a.m., revealed the resident had a blood sugar of 506 and received 8 units of insulin. Review of nursing notes revealed the physician was notified after the insulin was given and the physician also ordered 10 units of Novolin R insulin and bedtime Lantus insulin increased to 10 units.

Review of nursing notes dated October 17, 2011, at 5:00 p.m., revealed 'yes (resident's) BS (blood sugar) 517, rock (recheck) 488 - MD called - ordered Novolin R 10 units now and to have Lantus insulin 20 units at HS (hours of sleep). Review of the MAR revealed no sliding scale insulin was administered.

Interview with the Medical Director on October 19,
F 281 Continued From page 9
2011, at 8:10 a.m., in the conference room, revealed if a resident had a blood sugar > 400 the physician wanted to be called prior to administration of sliding scale insulin to prevent the resident from having two injections and to administer a dose of insulin more individualized to the resident.

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, and interview, the facility failed to prevent a medication error rate of greater than 5% (5 percent), for three medication errors, error rate of 6%, out of forty-nine opportunities observed on two of three halls.

The findings included:

Observation of a medication pass on October 18, 2011, at 7:45 a.m., on the 300 hallway, revealed Licensed Practical Nurse (LPN) #2 administered the following medications to resident #8:

Namenda 10 milligrams (mg), Protonix 40mg, Potassium Chloride 10 milliequivalents (meq), Vitamin C 500mg, Cymbalta 60mg, Brufenol solution 0.09 percent and Dexametomidine-Timolol solution 22.3/6.8 percent.

Medical record review of the Admission Orders dated August 25, 2011, revealed the resident was...
Continued From page 10

to receive Calcium Carbonate (Tums) 1000mg every four hours and Multivitamin daily.

Review of the physician's recalculation orders for October 1 - 31, 2011, signed by the physician October 6, 2011, revealed "Calcium A /acid 500 mg chew, 2 every 4 hours and as needed", and Multivitamin daily.

Interview with LPN #2 on October 18, 2011, at 8:22 a.m. and 9:25 a.m., at the nursing station confirmed the resident was to receive Tums every 4 hours and a multivitamin daily and the medications had been omitted during medication pass.

Observation of a medication pass on October 18, 2011, at 9:25 a.m. in the resident's room, revealed LPN #1 handed a medication cup to the resident, containing the following medications:
Zinc Sulfate 220mg, Lexapro 10mg, Alivam 1mg, Vitamin C 500mg, Calcium 600mg with 400 international units of Vitamin D, Pepcid 20mg, Ferrous Sulfate 325mg, Folic Acid 1mg two tablets, Magnesium Oxide 400mg, Multivitamin with minerals one tab, Oxycodone 10/325mg.
Further observation revealed, while taking the medications the resident dropped two pills into the bed and the LPN retrieved one pill for the resident to take. Further observation revealed the LPN exited the resident's room and stated the resident had taken all the medications.

Interview and observation with LPN #2 on October 18, 2011, at 9:55 a.m., in the resident's room, confirmed one tablet of Folic Acid 1mg, was hidden in the folds of the resident's sheets and the LPN was unaware the resident had
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<th>ID</th>
<th>Description</th>
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<tr>
<td>F 332</td>
<td>Continued From page 11 dropped it</td>
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<tr>
<td>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</td>
<td>F 332</td>
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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 on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, review of facility policy, review of the facility's Borrower Medication Log, Review of Narcotic Logs, and interview, the facility failed to accurately track acquisition and disposition of medications for four residents (#3, #11, #19, and #20) of twenty residents reviewed.

The findings included:

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<tr>
<th>ID</th>
<th>Corrective Action</th>
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<tbody>
<tr>
<td>F 425</td>
<td>Description</td>
</tr>
<tr>
<td>SS-D</td>
<td>The facility will accurately track acquisitions and disposition of medications for residents.</td>
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</table>

1. Medications borrowed from residents #3, #11, #19 and #20 were replaced on 10/20/11.
2. DON and ADON conducted an audit from 7/1/11 thru 10/10/11 to identify any residents who had medications borrowed to ensure they had been properly replaced. This audit was conducted from 10/20/11 thru 10/25/11.
3. Nursing staff was in-service on 10/19/11 with all staff on duty and with staff prior to reporting to duty.
4. DON and ADON will monitor for compliance during daily audits 100% for 3 months then 50% for 3 months, 25% for 3 months and then random audits weekly.
5. Findings will be reported to the QA Committee who will review and add new interventions or goals as needed. The QA Committee consist of the Medical Director, Administrator, DON, ADON, MDS Coordinator, Medical Records, Social Activities, Food Services, RD, Bookkeeping, Payroll, Maintenance and Environmental Services.

11/2/11
F 425 Continued From page 12

Resident #3 was admitted to the facility on September 7, 2008, with diagnoses including Depression and Alzheimers.

Medical record review of a physician's telephone order dated March 29, 2011, revealed, "Borrow Xanax (for anxiety) 0.25 mg (milligram) (1) tab (tablet) for another resident ...".

Resident #11 was admitted to the facility on July 9, 2010, with diagnoses including Atypical Psychosis and Alzheimer's.

Medical record review revealed the following physician's telephone orders: October 8, 2011, "Replace (1) Xanax 0.5 mg: borrowed for another pt (patient) ..."; October 9, 2011, "Replace (1) Xanax 0.5 mg borrowed for another pt ..."; October 9, 2011, "Replace (1) Xanax 0.5 mg/Borrowed for another pt ..."; October 10, 2011, "Replace (1) Xanax 0.5 mg: borrowed for another pt ..."; October 13, 2011, "Replace (1) Xanax 0.25 mg: borrowed for another pt ..."; October 13, 2011, "Replace (1) Xanax 0.5 mg: borrowed for another pt ..."; and, October 14, 2011, "Replace Xanax 0.5 mg (1) borrowed for another pt ...

Resident #19 was admitted to the facility on December 22, 2008, with diagnoses including Multiple Sclerosis and Depression.

Medical record review of a telephone physician’s order dated October 3, 2011, revealed "Replace 2 Loratadine (schedule II narcotic for pain) 1.5/500 mg borrowed for another resident ...".

Review of the facility's policy Borrowing of Meds
Continued From page 13

dated August 2010, revealed, "...When a medication order is received after order cut-off time for (named pharmacy) or on weekends/holidays, the following procedure must be followed ...5. If delivery from either the backup pharmacy or (named pharmacy) does not meet the immediate therapeutic needs of the patient, i.e. medication won't be delivered within an accepted administration time frame, borrow the medication. 6. The Borrowed Medication Log (Form 4315) must be completed for any meds borrowed including the nurse's signature and forwarded to the DON (Director of Nursing) ..."

Review of the Narcotic Log book located on the 200 hall medication cart revealed a page for Lortab 5/325 mg assigned to a resident (Resident #20) indicated on eight different lines the medication had been borrowed to be administered to another resident.

Medical record review of a telephone physician's order for resident #20 dated October 10, 2011, revealed, "Replace (8) eight Lortab 5/325 mg borrowed for another resident ...

Review of the facility's Borrowed Medication Log revealed logs had been completed for medications borrowed from one resident and administered to another resident between September 25 and October 14, 2011. Review of the log revealed no logs were in the book for any dates between October 5-10, 2011, and no recordings were in the book for the borrowed medications for resident #11 on October 8, 9, and 10, resident #19 on October 3, or resident #20 on October 10, 2011.
F 425  Continued From page 14
Interview with the DON on October 18, 2011, at 4:00 p.m., in the conference room, revealed the facility’s process for borrowing medications were as follows: borrowed medications from one resident to another resident were logged in the Borrowed Medication Log by the nurse; orders were signed by the physician and faxed to the pharmacy; the pharmacy sent the prescription pills to the facility; the nurses replaced the medications when received; the consultant pharmacist reviewed the log book monthly for accuracy; and all documentation was discarded after the consultant pharmacy review. Further interview confirmed no documentation was completed to ensure replacement medications were received from the pharmacy when ordered.

Interview with the Consultant Pharmacist by phone on October 19, 2011, at 8:50 a.m., confirmed the Pharmacist reviewed the Borrowed Medication Log book monthly for possible discrepancies. Further interview confirmed the Pharmacist relied on the log book for information regarding the borrowing of medications and was not doing chart audits for every resident and comparing it to the log book or confirming the receipt of replacement medications. Further interview revealed if the log book was not accurate and if the nurses had not completed an entry in the log book, then the Consultant “...may not know...” a medication had been borrowed from one resident for another resident.

Interview with the Administrator and DON on October 19, 2011, at 9:25 a.m., in the Administrator’s office, and review of additional Borrowed Medication Logs and interview with DON at 10:50 a.m., in the conference room,
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<td>F 425</td>
<td>Continued From page 16. Confirmed the DON held the missing logs for all of the medications except resident #19's two Lorabids borrowed on October 3, 2011, but they had not been placed in the log book. Further interview confirmed the facility did not maintain records or documentation of receipt of medications when replaced by the pharmacy. Further interview confirmed the facility could not provide complete and accurate tracking of receipt and disposition of medications.</td>
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<tr>
<td>F 431</td>
<td>SS-D 483.60(b),(d),(e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</td>
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<td>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.</td>
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<td>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.</td>
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<td>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.</td>
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<td>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the</td>
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F 431 Continued From page 17
 or administration instructions. Observation of the
 bottom drawer of the cart revealed 18 packages
 labeled Coumadin 6mg tab without a prescription
 label indicating resident name, date, or
 administration instructions.

 Interview with LPN #2 on October 18, 2011, at
 2:05 p.m., in the medication room confirmed the
 omeprazole was beyond the expiration date, was
 not labeled, and was available for use, and the
 receipt and disposition of the Coumadin was
 unknown.

 Observation on October 18, 2011, at 2:15 p.m., in
 the medication room revealed a storage cart
 containing the following items: three sterile foam
 tipped applicators with an expiration date of
 August, 2010, one Para Pack culture and
 sensitivity container with an expiration date of
 November, 2010, two wound culture tubes with
 an expiration date of June, 2011, hem scut
 developer with an expiration date of March 2011,
 five purple top vacucontainers (for blood collection)
 with an expiration date of March, 2011, and one
 unlabeled Serum Separator Tube (SST)
 vacucontainer filled with an unknown clear liquid.

 Interview with the Assistant Director of Nursing on
 October 18, 2011, at 2:15 p.m., in the medication
 room, confirmed the biologicals were available for
 use beyond the expiration date and the SST
 vacucontainer had been stored unlabeled with an
 unknown fluid.

 F 441 483.65 INFECTION CONTROL, PREVENT
 SPREAD, LINENS

 The facility must establish and maintain an
 Infection Control Program designed to provide a
### F 441

**Continued From page 18**

Safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program  
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection  
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(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 medical record reviews, observations,

**Corrective Action**

1. Isolation sign was replaced on resident #4 door on 10/17/11 and the isolation cart for resident #6 was placed outside the patient room on 10/18/11 by DON.
2. Facility rounds were made on 10/18/11 to ensure that signs were on the doors for isolation patients and that isolation carts were positioned outside of patient rooms per protocol on 10/18/11.
3. Facility staff were instructed on 11/2/11 regarding proper isolation procedures by the Administrator and DON.
4. DON, ADON and Weekend Supervisor will monitor for compliance during daily walking rounds.
5. Findings will be reported to the QA Committee who will review and set new interventions and goals as needed. The QA Committee consist of Medical Director, Administrator, DON, ADON, MDS Coordinator, Medical Records, Social Activities, Food Services Supervisor, RD, Bookkeeping, Payroll, Maintenance and Environmental Services.
F 441 Continued From page 19

Interviews, and policy review, the facility failed to follow infection control guidelines for two (#4 and #6) residents of twenty residents reviewed.

The findings included:

Medical record review revealed Resident #4 was admitted to the facility on August 1, 2011, with diagnoses which included: Un-stageable Pressure Ulcer, Anemia, and Urinary Tract Infection. Review of a physician's progress note dated October 12, 2011, revealed the resident was diagnosed with, "C Diff (Clostridium Difficile a microscopic organism which can cause severe diarrhea and other intestinal disease) colitis (inflammation of the bowel)."

Review of Laboratory Reports dated October 11, 2011, revealed Resident #4's stool specimen was positive for Clostridium Difficile (C-diff).

Review of Resident #4's care plan dated October 12, 2011, revealed, "Contact Isolation as ordered and indicated R/T (related to) recur CDIFF."

Observations, on October 17, 2011, at 1:05 p.m., 2:30 p.m., and 4:00 p.m., revealed no sign on the door to resident #4's room instructing visitors to see nurse before entering the resident's room.

Review of the facility's undated policy titled, "Isolation", revealed, "Isolation Room Sign. This sign must be placed on the door to the patient room instructing visitors to see nurse before entering room..."

Interview with Licensed Practical Nurse (LPN #1), on October 17, 2011, at 4:25 p.m., outside
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<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LCIC IDENTIFYING INFORMATION)</th>
<th>ID 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>
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| F 441        | **Continued From page 20**  
Resident #4's room, confirmed there was no sign on the resident's door instructing visitors to see nurse before entering the room. LPN #1 also stated a sign should have been on the door.  
Interview with the Director of Nursing (DON), on October 17, 2011, at 4:30 p.m., in the facility's beauty shop, confirmed Resident #4 was on contact isolation due to C-diff. Further interview with the DON confirmed a sign instructing visitors to see the nurse before entering room, must be on the door of resident rooms on contact isolation.  
Medical record review revealed Resident #6 was admitted to the facility on June 23, 2011, with diagnoses which included: Congestive Heart Failure, Atrial Fibrillation, and Hypertension.  
Review of laboratory reports dated September 29, 2011, revealed the resident tested positive for C-Diff.  
Review of physician's orders dated October 1, 2011, revealed order for, "contact isolation for c-diff."  
Review of Resident #5's care plan, dated October 11, 2011, revealed, "contact isolation for c-diff."  
Observation of Resident #5's room, on October 18, 2011, at 8:00 a.m. and 9:00 a.m., revealed the storage bin containing isolation supplies, gowns, plastic bags, and gloves, placed inside the room.  
Review of the facility's undated policy titled, | F 441 | | | |
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"Isolation" revealed, "...Placement of equipment and supplies...Outside the room...small table or cabinet...with supply of clean gowns, gloves and masks...garbage bags."

Interview with the DON, on October 1st, 2011, at 9:10 p.m. in the conference room, revealed the storage bin must be kept outside the room with contact isolation.

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

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview the facility failed to provide timely laboratory services for one resident (#3) of twenty residents reviewed.

The findings included:

Resident #3 was admitted to the facility September 7, 2008, with diagnoses in including CVA (Stroke) with Right Sided Weakness, Hypertension, Depression, and Alzheimers Dementia.

Medical record review of a physician's order dated September 6, 2011, revealed "...UA (urinalysis) to rule out UTI (urinary tract infection)...

Medical record review of a nurse's note dated
**NORTHSIDE HEALTH CARE CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
202 EAST MTCS ROAD
MURFREESBORO, TN 37130

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<td>F 602</td>
<td>Continued From page 22</td>
<td>F 502</td>
<td>Supervisor and Environmental Services</td>
<td>11/2/11</td>
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October 7, 2011, at 1 p.m., revealed "...Lab results received from UA MD (Medical Doctor) to review..."

Medical record review of a laboratory report dated October 7, 2011 at 12:25 p.m., revealed "...Urinalysis...Collection Date 9/7/2011, 12:30 a.m....Received Date 9/7/2011, 7:39 p.m....Date Reported 10/7/2011, 12:25 p.m...." and a handwritten report "...MD review 10/7/2011 1 p.m. upon rounds..." and "...10-10-2011 started on Cipro 250 mg (milligrams) 1/4 (1 tablet) BID (twice daily) x 7 days UTL..."

Interview with the DON (Director of Nursing), in the conference room, on October 18, 2011, at 3:00 p.m., confirmed the facility did not follow-up timely on the resident's urinalysis result and the urinalysis lab result was not reported timely to the physician.