DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 12/04/10

PRINTED: 10/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445107		10/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, FT SANDERS	2120 HIGHLAND AVE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
	Investigation of complaint #26820 was completed with the annual survey October 18-20, 2010, at NHC Ft Sanders. No deficiencies were cited in relation to complaint #26820 under 42 CFR Part 483, Requirements for Long Term Care Facilities.			
F 221 SS=D	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, observation, and interview, the facility failed to assess for use of a physical restraint for one resident (#12) of twenty-four residents reviewed. The findings included: Resident #12 was admitted to the facility on May 7, 2009, with diagnoses including End Stage Alzheimer's Disease, Dementia, Osteoporosis, and Lower Extremity Contractures. Medical record review of the Minimum Data Set (MDS) dated September 3, 2010, revealed the resident had impaired long and short term memory; severely impaired cognitive skills; required total assistance for all activities of daily living; had not experienced any fall in the last 180 days; and did not use any devices or restraints. Medical record review of the Care Plan dated April 14, 2010, and updated September 9, 2010,	F 221	F 221 1. Resident reassessed for restraints by MDS nurse. Wedge removed from resident #12's bed, continue with upper and lower raised siderails for patient safety. 2. All residents identified as falls risks reviewed by nurse risk managers. No other residents found to be affected. 3. In-service completed with all licensed and certified nursing staff regarding the proper use of positioning equipment and restraints. Nurse supervisors will monitor for inappropriately placed restraints during routine rounds. 4. Floor supervising RN and Risk Management Nurse, in coordination with the Falls RN, will complete routine rounds monitoring for inappropriately placed positioning equipment and/or restraints.	10/21/10 10/21/10 10/27/10 10/27/10 10/27/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Douglas S. Ford
TITLE: N.H.A
(X6) DATE: 11/2/10

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 these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 revealed the resident was at risk for falls; was to have a clip alarm on at all times; and the bed was to be against the wall with safety mats on the open side. Medical record review of the Side Rail Assessment completed September 3, 2010, revealed, "Patient requires assist with bed mobility and transfers. Upper Side Rails do not restrict current physical capabilities and are not a restraint. Lower Rails are not elevated." Medical record review of the High-Risk Patient Selection Form dated September 3, 2010, revealed, "H/O (history of) falls - End Stage Alzheimers (with) disorientation @ (at) all times. Risk for falls. Clip alarm/Bed against wall for fall prevention." Observations of the resident on October 18, 2010, at 8:00 a.m., 10:45 a.m., and 4:10 p.m., revealed the resident in bed, with the bed against the wall; upper and lower side rails raised on the side of the bed away from the wall; and a wedge cushion, underneath the fitted sheet, filling the space between the upper and lower side rails. Observation of the resident on October 19, 2010, at 8:00 a.m., and 8:20 a.m., revealed the resident in bed, with the bed against the wall; upper and lower side rails raised on the side of the bed away from the wall; and a wedge cushion, partially underneath the fitted sheet, filling the space between the upper and lower side rails. Interview with CNA (certified nurse aide) #1 on October 19, 2010, at 8:10 a.m., in the resident's room, confirmed both upper and lower side rails were raised, and a wedge cushion was placed in	F 221	See page 1 of 9	

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F 221	Continued From page 2 the space between the side rails because the resident would hang the legs over the side of the bed, between the rails, and was at risk for falling out of the bed. Interview with the LPN/MDS (licensed practical nurse) Careplans staff member on October 19, 2010, at 8:20 a.m., in the resident's room, confirmed the resident would attempt to swing legs between the side rails and sit on the side of the bed, placing the resident at risk for falling. Continued interview confirmed the resident did not have any safety awareness and was not able to understand or retain instructions from staff. Continued interview confirmed the wedge between the raised side rails prevented the resident from sitting on the side of the bed, which was a restraint, and the resident had not been assessed for the use of restraints. Interview with the MDS Coordinator on October 19, 2010, at 10:05 a.m., in the resident's room, confirmed the resident was assessed for the upper side rail to be raised, not the lower side rail, and the resident was capable of removing the wedge. Interview with the Second Floor Nurse Manager on October 20, 2010, at 8:45 a.m., in the resident's room, confirmed the resident had not been assessed for the lower side rail being raised, and confirmed the resident was not capable of removing the wedge when placed underneath the fitted sheet, which was a restraint for the resident.	F 221	See page 1 of 9	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281	See page 4 of 9	

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F 281	Continued From page 3 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 notify the physician of a resident's pain and obtain an order before administering medications for one resident, (#13), of twenty-four residents reviewed. The findings included: Resident #13 was admitted to the facility October 28, 2009 with diagnoses including: Multiple Therapies, Left Hip Fracture with Repair, Alzheimer's disease, Dementia, Parkinson's disease, and Gait Disturbance. Medical record review of the physician's order dated April 5, 2010 revealed "Discontinue hydrocodone (non-use)..." Medical record review of the nurse's note dated April 17, 2010 at 2 a.m., revealed " ...c/o (complaint of) Rt. Hip, groin, leg pain...PRN (as needed) given at 12:45 a.m..." Medical record review of the Narcotic Inventory Record dated April 17, 2010, revealed the resident received one Hydrocodone/APAP 5/325 mg (milligrams - pain medication) at 12:45 a.m. Medical record review of the facility Narcotic Inventory Record for Resident #13 revealed an additional dose of hydrocodone/apap 5/325 milligrams (mg) was signed out by LPN #2 at 6:45 a.m. April 17, 2010. Medical record review of the nurse's notes	F 281	F281 1. Physician notified of new on-set pain and clarification order for hydrocodone/APAP 5/325 received for resident # 13 on 04/17/10 by RN house supervisor. 2. Any residents with falls in the last 30 days, and receiving narcotic pain medication, were reviewed. No other residents found to be affected. 3. In-service completed with all licensed nursing staff regarding appropriate physician notification of any new onset of pain and resident change of status and obtaining orders for treatment. 4. Floor RN supervisors and RN shift supervisors will review record of any residents reported to have new onset pain for appropriate physician notification and orders received for treatment at time of report. ADON to do random audits assessing for appropriate physician notification and orders received for treatment on any patient identified as having new onset pain.	04/17/10 10/21/10 10/27/10 10/27/10 10/27/10

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F 281	Continued From page 4 revealed no documentation the physician was notified on April 17, 2010, at 12:45 a.m., or 6:45 a.m., of the resident's pain or for a request from the nurse to the doctor for an order for pain medication. Interview with the DON on October 20, 2010 at 2:10 p.m., in the conference room, confirmed the third shift nurse, LPN#2, failed to report the resident's new onset of pain to the physician and failed to get an order for the narcotic pain medication given twice on third shift at 12:45 a.m. and 6:45 a.m. on April 17, 2010.	F 281	See page 4 of 9	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH 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	F 425	See page 6 of 9	

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F 425	Continued From page 5 by: Based on medical record review and interview, the facility failed to ensure the safe administration of medication for one resident of twenty-four residents reviewed. The findings included: Resident # 13 was admitted to the facility October 28, 2009 with diagnoses including: Multiple Therapies, Left Hip Fracture with Repair, Alzheimer's disease, Dementia, Parkinson's disease, and Gait Disturbance. Medical record review of the physician's order dated April 5, 2010 revealed "Discontinue hydrocodone (non-use)..." Medical record review of the nurse's note dated April 17, 2010 at 2 a.m. revealed "...PRN (as needed) given at 12:45 a.m." Medical record review of the Narcotic Inventory Record dated April 17, 2010, revealed the resident received one Hydrocodone/APAP 5/325 mg (milligrams - pain medication) at 12:45 a.m. Medical record review of the facility Narcotic Inventory Record for Resident #13, dated December 3, 2009, revealed the medication, (hyrocodone/apap 5/325 mg) was still available to dispense and LPN #2 had signed out a dose of one tablet April 17, 2010 at 12:45 a.m. and another tablet at 6:45 a.m. April 17, 2010. Medical record review of the facility Medication Administration Record for Resident #13 dated April 1, 2010 through April 30, 2010, revealed the medication, hydrocodone/apap 5/325 mg., was marked " ...d/c 4-5-10" and no documentation,	F 425	F425 1. Physician notified by RN house supervisor on 04/17/10 that resident #13 receiving discontinued pain medication. New orders received. 2. Residents receiving narcotic pain medication reviewed for current orders. No others found to be affected. 3. In-service with all licensed staff reviewing appropriate procedure for giving as needed medication and removal of discharged medications from medication cart at time of discontinue order received. Nurses to review narcotic logs at each change of shift and remove any medications with non-active orders according to policy. 4. Medication carts to be assessed routinely by quality assurance nurse for removal of discontinued medications. Ongoing reviews of narcotic logs by the Pharmacist Consultant. Reviews will include monitoring for inactive medications on medication cart.	04/17/10 10/21/10 10/27/10 10/27/10 10/27/10 11/04/10

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F 425	Continued From page 6 front or back, by LPN #2 that the medication was given twice on April 17, 2010. Interview with the Director of Nursing (DON) at 2:10 p.m. October 20, 2010 in the conference room, confirmed LPN #2 administered two doses of hydrocodone /apap without a physician's order.	F 425	See page 6 of 9	
F 431 SS=D	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. 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	F 431	F431 1. Loose pills found in 2nd floor medication cart destroyed according to policy. 2. All other medication carts reviewed. No other carts found to be affected. 3. In-service with all licensed nursing staff to review procedure regarding storage of medications and maintenance of medication carts. Medication carts to be assessed for loose medication with any change of responsible nurse for the medication cart. Any loose medication found to be identified, credited to the resident and destroyed according to procedure. 4. Monthly audits by the Pharmacist Consultant to include assessing the medication carts for loose medication.	10/20/10 10/21/10 10/27/10 11/04/10

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F 431	Continued From page 7 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to store and maintain an accurate record of medication disposition for one medication cart of four observed. The findings included: Observation of a medication cart at the second floor nursing station on October 20, 2010, from 1:15 p.m. until 1:30 p.m., revealed the cart had six drawers which contained residents' medications in cardboard blister-pack sheets (individual pills pushed through a foil cover on the back of the sheet). Further observation revealed each drawer contained medications for multiple residents based on the room number. Further observation on October 20, 2010, from 1:15 p.m., until 1:30 p.m., revealed the first drawer had three loose pills in the bottom of the drawer; the second drawer had four loose pills in the bottom of the drawer; the third drawer had two loose pills in the bottom of the drawer; the fourth drawer had six loose pills in the bottom of the drawer; the fifth drawer had four loose pills in the bottom of the drawer; and the sixth drawer had six loose pills in the bottom of the drawer. Interviews with the second floor nurse manager and Licensed Practical Nurse #1 on October 20, 2010, from 1:15 p.m., until 1:30 p.m., at the second floor nursing station, confirmed there	F 431	See page 7 of 9	

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F 431	Continued From page 8 were multiple pills loose in the bottoms of the medication drawers, and the pills could not be identified as to what medication or which resident. Further interviews confirmed the medications were not properly stored and accounted for.	F 431	See page 7 of 9	

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