STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445107	A. BUILDING _____ B. WING _____	**03/04/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interview, the facility failed to ensure adequate supply of medications were available for 1 resident (Resident #285) of 5 residents reviewed for medication administration, resulting in staff borrowing pain medication from Resident #59 to administer to Resident #285. The findings include: Review of the facility policy titled, Preparation And General Guidelines, revised 1/1/2019, showed .Medications are administered as prescribed in accordance with good nursing principles and practices .Medications supplied for one resident should not be administered to another resident . Review of the facility policy titled, Controlled Substances (Narcotic) Administration Procedure Medication Exchange Procedure (Borrowing Medications), revised 7/15/2019, showed .If necessary, to borrow a narcotic medication, you are to utilize the medication exchange sheet .When completed, fax the completed form to Pharmacy before the end of your shift . Resident #59 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #59's Physician Order Report showed an order dated 1/29/2019 for [MEDICATION NAME] (also known as [MEDICATION NAME], a narcotic pain medication) 10-325 mg (milligrams). Resident #285 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #285's Physician Order Report showed an order dated 2/27/2020 (the order had been received prior to the admission) for [MEDICATION NAME] 10-325 mg. The medication was to be administered every 6 hours as needed. Review of Resident #285's Narcotic Count Sheet showed the resident had a supply of 8 tablets of [MEDICATION NAME] 10-325 mg. The resident had received a total of 8 tablets from 2/28/2020 - [DATE]. The Narcotic Count Sheet showed 0 tablets remained in the resident's supply on [DATE] at 4:57 PM. Review of Resident #285's Medication Administration History dated [DATE]-3/3/2020 showed Resident #285 had received [MEDICATION NAME] 10-325 mg on [DATE] at 10:58 PM, on [DATE] at 6:53 AM, on [DATE] at 1:14 PM, on [DATE] at 7:25 PM, on 3/3/2020 at 1:59 AM, and on 3/3/2020 at 9:16 AM. (a total of 6 doses after the original supply of 8) Observation on 3/3/2020 at 9:08 AM showed Licensed Practical Nurse (LPN) #1 approached LPN #2 at a medication cart and asked to borrow an [MEDICATION NAME] from Resident #59's medication supply to administer to Resident #285. LPN #2 obtained the medication from Resident #59's supply and gave the medication to LPN #1. During an interview on 3/3/2020 at 9:11 AM, LPN #1 confirmed the medication was not available in the facility's emergency narcotic box. LPN #1 stated she had worked on [DATE] and Resident #285 did not have a supply of [MEDICATION NAME] on that day. She had borrowed the medication from Resident #59 on [DATE] to administer to Resident #285. She had faxed the order to the pharmacy to refill on [DATE]. Observation on 3/3/2020 at 9:15 AM, showed LPN #1 administered the medication she had obtained from Resident #59's medication supply to Resident #285. During an interview on 3/3/2020 at 9:18 AM, Registered Nurse (RN) #1 confirmed she was made aware Resident #285 did not have a supply of the physician ordered [MEDICATION NAME] on [DATE]. She had faxed the refill request to the pharmacy on [DATE] but had not called the pharmacy to ensure the medication would be filled. RN #1 stated when a resident does not have an ordered medication the facility will first check the emergency medication box. If the medication is not available in the emergency medication box then they check to see if another resident in the building has the medication and the medication is then borrowed from the other resident. During an interview on 3/3/2020 at 3:14 PM, the Director of Nursing (DON) confirmed [MEDICATION NAME]\[MEDICATION NAME] 10-325 mg was not available in the facility's emergency narcotic box. During a phone interview on 3/3/2020 at 3:46 PM, the Pharmacy Director confirmed the facility borrowed medications from other residents if it's an emergency situation. The Pharmacy Director stated Resident #285 had been admitted on [DATE]. The pharmacy had received the admission orders [REDACTED]. The Pharmacy Director had sent a spreadsheet by e-mail to the facility on [DATE] at 9:34 AM which indicated the facility would need to obtain a physician signed prescription for the medication to be refilled. The pharmacy had not received the physician signed prescription until 3/3/2020. The Pharmacy Director stated if a medication is not available in the facility's emergency medication supply the facility could obtain an emergency refill if the pharmacy spoke directly with the physician or the facility could contact the physician and request an order for [REDACTED]. The Consultant Pharmacist confirmed borrowing medications from other residents was not the standard of practice and increased the risk for medication errors. The Consultant Pharmacist also confirmed the facility can contact the Physician if the medication was unavailable and request the medication order to be changed to another medication that was available in the facility's emergency box. During an interview on 3/3/2020 at 5:01 PM, the DON confirmed the facility had received the e-mail from the pharmacy on 2/28/2020 which notified the facility Resident #285 required a signed prescription for the refill of the [MEDICATION NAME] 10-325 mg. The DON also confirmed the facility's Nurse Practitioner (NP) was available at the facility Monday-Friday but the facility had not obtained a signed prescription from the NP to refill the [MEDICATION NAME] 10-325mg on 2/28/2020 after they had received the e-mail from the pharmacy. During an interview on 3/4/2020 at 12:52 PM, Resident #285's Attending Physician confirmed the facility made her aware Resident #285's physician ordered pain medication had not been available. The Attending Physician stated if the medication was not available in the facility's emergency medication box then they could borrow it from another resident. During an interview on 3/4/2020 at 1:44 PM, the Medical Director confirmed he was aware of the facility's practice of borrowing medications from one resident to administer to another resident if the medication was not available. During an interview on 3/4/2020 at 2:47 PM, the DON confirmed the facility had borrowed a total of 6 tablets of [MEDICATION NAME] from Resident #59 to administer to Resident #285. The DON confirmed the facility had not maintained an adequate supply of medications for Resident #285. In summary: The facility had conflicting policy's regarding the borrowing of medications and the facility had not obtained a signed prescription to refill a narcotic pain medication timely for Resident #285. The medication had been borrowed from another resident which increased the risk for medication errors.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, medical record review, observation, and interview, the facility failed to follow infection control guidelines for 1 resident (Resident #89) of 3 residents reviewed for isolation precautions. The findings include: Review of the facility policy, titled, Contact Precautions', revised 11/2019, showed .use Contact Precautions for patients to prevent transmission of infectious agents .which are spread by direct or indirect contact with the patient or the patient's environment. Infectious agents for which Contact Precautions are indicated include Multi-resistant organisms .such as .ESBL's (extended spectrum beta-lactamase/enzyme produced by some bacteria that can't be killed by antibiotics) .Personal Protective Equipment (PPE) .Healthcare personnel caring for patients should wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment . Resident #89 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of a Physician's Order dated 6/11/19 showed .Contact Isolation for ESBL IN URINE. Special Instructions .Use precautions when entering room . Observation of Resident #89's room on 3/4/2020 at 8:05 AM, showed a sign on the resident's door to go to the nurses station before entering. Certified Nursing Assistant (CNA) #1 was in the resident's room assisting the resident with the breakfast tray without a gown or gloves on. During an interview with CNA #1 on 3/4/2020 at 9:00 AM, the CNA stated

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Resident #89 was in isolation but was unsure what PPE should be worn when entering the resident's room. CNA #1 confirmed she had not donned a gown or gloves prior to entering Resident #89's room. During an interview with the Assistant Director of Nursing (ADON) on 3/4/2020 at 9:30 AM, the ADON stated Resident #89 is on Contact Precautions and it was her expectation that all staff wear a gown and gloves prior to entering the resident's room.