STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

SUMMIT VIEW OF LAKE CITY, LLC

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE
204 INDUSTRIAL PARK RD
LAKE CITY, TN 37769

DATE OF SURVEY COMPLETED
01/30/2013

ID NUMBER
445259

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)

(X3) COMPLETION DATE

F 000 INITIAL COMMENTS

The annual recertification and complaint investigations #s TN-31053, TN-30990, TN-30719, TN-30863, TN-31122 were completed on January 28 - 30, 2013. No deficiencies were cited for complaint TN-31053 under 42 CFR PART 482.13, Requirements for Long Term Care.

F 203 NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE

1. The facility will give written notice of transfer or discharge. Resident # 82 was discharged as an immediate transfer related to an urgent medical need.

2. All discharges will be reviewed in the daily clinical meeting by Social Services, Director of Nursing, Unit Managers, and Administrator to ensure correct notice of transfer or discharge.

3. In-service was conducted by Administrator on 2-13-13 to include Case Management, Social Services, Director of Nursing, Unit Managers and Admissions on notice of transfer or discharge.

4. This will be monitored in daily clinical meeting and monthly Quality Assurance Meeting by Social Services and Administrator.

Except when specified in paragraph (a)(5)(II) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(I) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(II) of this section; or a resident has not resided in the facility for 30 days.

[Signature]
Administrator 3-13-13
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>203</td>
<td>Continued From page 1 The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</td>
<td>203</td>
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<td>3-6-13</td>
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This **REQUIREMENT** is not met as evidenced by:

Based on medical record review and interview, the facility failed to provide written notice of transfer or discharge for one resident (#82) of forty-eight residents reviewed.

The findings included:

Resident #82 was admitted to the facility on October 3, 2012, with diagnoses including Pneumonia, Infection with Drug Resistant Microorganisms Resistant to Penicillins, Anoxic Brain Injury, Convulsions, Disturbance of Conduct, Psychosis, and Depressive Disorder.
F 203

Continued From page 2

Medical record review of the resident's admission Minimum Data Set (MDS), dated October 10 2012, revealed the resident scored a six on the Brief Interview for Mental Status (BIMS) indicating the resident was severely cognitively impaired and the resident required minimal assistance with activities of daily living.

Medical record review of a Social Services Interdisciplinary Progress note, dated October 6, 2012, at 2:10 p.m., revealed "...talked with resident's wife and does not want resident to come home...states...has not become POA (power of attorney) over the resident...informed...that resident is...own responsible party and we cannot force...to stay..."

Medical record review of a physicians order, dated November 11, 2012, revealed "...send to... (named hospital) for mental status change and fall..."

Medical record review of a nurse's note, dated November 11, 2012, at 1658 (4:56 p.m.), revealed "...called to room by Certified Nurse Assistant (CNA) found resident lying on the floor on right side...assessed by LPN (Licensed Practical Nurse) and RN (Registered Nurse) supervisor...resident refuses to walk...notified... (named physician)...to send to ER (emergency room) for tx (treatment) and eval (evaluation) and mental status changes..."

Medical record review of a nurse's note, dated November 12, 2012, at 1:47 a.m., revealed "...resident has been admitted to...(named hospital) with a RT (right femur fracture..."
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 445259

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED 01/30/2013

NAME OF PROVIDER OR SUPPLIER
SUMMIT VIEW OF LAKE CITY, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
204 INDUSTRIAL PARK RD
LAKE CITY, TN 37769

(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)

F 203
Continued From page 3
Interview on January 30, 2013, at 3:45 p.m., with the facility administrator, in the administrator's office, revealed "...the resident had a fall on November 11, 2012, and was transferred for evaluation and treatment...corporate case management concluded the resident was not appropriate for the facility...requires too much assistance than we can provide...cannot put another resident in jeopardy related to safety...we just cannot meet...needs..." Further interview with the administrator confirmed the facility did not give the resident written discharge or transfer information and the facility did not readmit the resident to the facility.

C/O # 31122
483.25(h) 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.

F 323
1. The facility will maintain safety devices for placement and placement and functioning. Resident #9 is discharged from facility.
2. Alarm placement and functioning placed on E-MAR for function and nurses to check while giving medications.
3. In-Service for charges nurses and CNAs on 2-18-13 by Unit Managers on position and functioning of safety devices.
4. Monitored by housekeeping Supervisor weekly to ensure functioning and monthly quality assurance meeting by Director of Nursing.

SS=D

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview the facility failed to ensure a safety device was in place and functioning for one resident (#9) of forty-eight residents reviewed.

The findings included:
Resident #9 was admitted to the facility from an
F 323 | Continued From page 4
acute care hospital on July 24, 2012, after a fall at home that resulted in a fractured right hip with surgical repair. Facility admitting diagnoses included Aftercare Right Hip Fracture, Anemia, Dysphagia, Hypothyroidism, Cardiopulmonary Disease, History of Left Arm Amputation.

Medical record review of the Minimum Data Set dated July 31, 2012, revealed the resident had clear speech, minimal difficulty hearing, severely impaired vision, and severe cognitive impairment.

Medical record review of the Initial Care Plan dated July 24, 2012, revealed "At risk for falls...Call light in reach...Encourage to ask for assist...clip alarm to alert staff of unassisted rising..." Continued medical record review of the facility Comprehensive Care Plan revealed updates dated August 16, 2012 and August 30, 2012, respectively, for the resident to have a low bed with fall mats on both sides of the bed and for the staff to be inserviced to place the clip alarm on the resident's tee shirt not the gown.

Medical record review of the facility Daily Skilled Nurse's Note dated August 30, 2012, at 4:30 p.m., revealed "...CNA (Certified Nursing Assistant) entered room - Resident lying on floor mat beside of bed - clip alarm was in use...(and) attached to gown - Resident had removed gown...0.5cm (centimeter) abrasion on Rt (right) foot...family notified."

Medical record review of the facility Nursing Progress Notes dated September 13, 2012, at 6:45 p.m., "...Roommate family to desk to tell me Resident was in floor. Went to room to find Resident sitting on floor pad...(no mention of
Continued From page 5
alarm sounding)... Nurse Practitioner (NP) notified... x-ray ordered and completed, negative for fracture, family notified..."

Medical record review of the facility Nursing Progress Notes dated September 28, 2012, at 9:30 p.m., revealed "...Discovered resident sitting on floor beside bed on mat..." Continued review of the facility Occurrence Report dated September 29, 2012, revealed "...Pt. (patient) had a hospital gown on and clip alarm was not attached...it was in the chair...NP notified, family notified..."

Medical record review of the Nursing Progress Notes dated October 6, 2012, at 1:15 a.m., revealed "...found resident on hands and knee...no clothing ...NP and family member notified." Further review of the facility Occurrence Report dated October 6, 2013, revealed "...resident with no clothes on...clip alarm attached to gown that was pulled off..."

Interview with the Director of Nursing (DON), on January 30, 2012, at 1:40 p.m., in the DON’s office, confirmed the facility failed to maintain the clip alarm in position and functioning for this resident.

Complaint #30863
483.30(e) POSTED NURSE STAFFING INFORMATION

The facility must post the following information on a daily basis:
- Facility name.
- The current date.
- The total number and the actual hours worked.
F 356

Continued From page 6

by the following categories of licensed and
unlicensed nursing staff directly responsible for
resident care per shift:
- Registered nurses.
- Licensed practical nurses or licensed
vocational nurses (as defined under State law).
- Certified nurse aides.
o Resident census.

The facility must post the nurse staffing data
specified above on a daily basis at the beginning
of each shift. Data must be posted as follows:
o Clear and readable format.
o In a prominent place readily accessible to
residents and visitors.

The facility must, upon oral or written request,
make nurse staffing data available to the public
for review at a cost not to exceed the community
standard.

The facility must maintain the posted daily nurse
staffing data for a minimum of 18 months, or as
required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview the facility
failed to post current and accurate staffing
information to reflect licensed and certified staff
present in the facility for each shift, each day, and
failed to maintain staff postings for eighteen
months as required.

Observation during the initial tour on January 28,
2013, at 4:20 a.m., in the main lobby area of the
facility, revealed the posted staffing was not

1. The facility will post nurse staffing at the
beginning of each shift and well maintain
staffing data as required by regulation.

2. The correct staffing data was posted on
1-30-13 by Staffing Coordinator.

3. An in-service conducted on 1-30-13 by
Staffing Coordinator to Charge Nurses
and Unit Managers on correct staffing
data to be posted every shift by charge
nurse. Staffing data will be maintained by
Staffing Coordinator.

4. This will be reviewed daily by Staffing
Coordinator or Unit Manager and
Monthly in Quality Assurance X4 by
administrator and Director of Nursing
**SUMMIT VIEW OF LAKE CITY, LLC**

<table>
<thead>
<tr>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>F 356</td>
<td>F 356</td>
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<td>3-6-13</td>
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Continued From page 7

current and did not accurately reflect the actual staff present in the building. The staffing posted was dated January 25, 2013 (three days prior) and listed only total staff hours, and did not specify the actual staff present for each shift. Five Certified Nursing Assistants (CNAs) and three Licensed Practical Nurses (LPNs) were present to provide care for one hundred and nine residents, when the survey team entered the facility.

Interview with LPN #1 on January 28, 2013 at 4:40 a.m., in the front lobby, confirmed the staffing posted was incorrect and outdated. The LPN stated "...don't know who updates this form or when...."

Interview with the Director of Nursing (DON) on January 28, 2012 at 8:10 a.m., in the conference room, confirmed the staffing posted was inaccurate and outdated from January 25 - January 26, 2013.

Interview on January 30, 2013, at 9:00 a.m., with the Staffing Coordinator (CNA #2) revealed CNA #2 was responsible for posting staffing and confirmed staffing was not posted on January 28, 2013.

Review of previous staff postings revealed the number of Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants were not posted. Interview with CNA #2 confirmed the posting of staff was completed in the mornings and total staffing hours were added from the schedule. Further interview confirmed the posting did not get addressed each shift and did not reflect the number or total hours of employees actually working. Continued interview
**SUMMIT VIEW OF LAKE CITY, LLC**

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<tr>
<td>F 356</td>
<td>Continued From page 8 confirmed posted daily nurse staffing data was not kept for eighteen months as required.</td>
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</tbody>
</table>

C/O # TN-30990

F 371

483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on observation and interview the facility failed to maintain equipment and food contact surfaces in a sanitary manner and failed to ensure proper storage of resident nourishments.

Findings included;
Observation on January 28, 2013 at 4:30 a.m. during the initial tour of the kitchen with the cook revealed the commercial mixer had dry brown and white debris on the beater shaft and dry light brown substance on the food processor. Continued observation revealed a reddish substance splashed on the walls behind the stove.

1. The facility will maintain equipment and food contact surfaces in a sanitary manner and ensure proper storage of resident nourishments.

2. The mixer, food processor walls behind stove were cleaned by dietary staff on 1-28-13. All wet stored pans were removed on 1-28-13 by Dietary Staff. The serving pans were cleaned by on 1-28-13 by Dietary Manager. All dented cans were removed on 1-28-13 by Dietary Manager. The ice machine and reach in cooler have been cleaned on 1-28-13 by Dietary Manager. The sink's recommended sanitization level was completed on 1-28-13 by Dietary Manager. The undated and out dated resident nourishments were removed from refrigerator on 1-28-13 by Dietary Manager.
SUMMIT VIEW OF LAKE CITY, LLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 445259

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
01/30/2013

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 371 Continued From page 9
Interview with the cook at the time of observation confirmed the mixer and the food processor were not clean. The cook stated the red substance on the walls "appeared to be tomato soup" and confirmed the walls were not clean.

Continued observation and interview revealed one 14 quart serving pan was wet with water droplets on the inside. Interview with the cook confirmed the pan had been cleaned and stored wet at 8:00 p.m. the night before. The cook stated pans should not be stored wet.

Continued observation on January 28, 2013, at 5:30 a.m. revealed a black crusty substance on the walls by the oven the inside of the oven was covered with a brown/black substance. Observation of serving pans stacked under the steam table in the clean area revealed ten of ten 49.9 ounce rectangular serving pans, four of four 36.4 ounce serving pans, three of three 21 quart serving pans, and one of one 22.5 ounce serving pan all with a black hard substance on the top and outside of the pans. The pans were stacked upside down on top of each other.

Interview with the Assistant Dietary Manager at the time of observation, confirmed the serving pans were not clean and properly stored.

Observation on January 28, 2013 at 5:45 a.m. in the dry storage area revealed one 117 ounce can of cranberry sauce with a dented upper rim. The can was stored with other cans to be prepared for resident consumption.

Interview with the Assistant Dietary Manager at the time of the observation confirmed the can

 provider's plan of correction (Each corrective action should be cross-referenced to the appropriate deficiency)

F 371 3. In-service was given on 2-11-13 by Dietary Manager to dietary staff on storing, preparing, distributing, and serving food under sanitary conditions. Cleaning schedules were updated to be more specific on items to clean. Routine check lists with date and initials by dietary staff of snacks to be posted in Nourishment room on a daily basis.

4. This will be monitored daily by Food Service Manager and Assistant Food Service Manager.

COM CMS-2557(02-09) Previous Versions Obsolete Event ID: V51M11 Facility ID: TN0102 If continuation sheet Page 10 of 18
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER: 445259

(X2) MULTIPLE CONSTRUCTION
A. BUILDING __________________________
B. WING __________________________

(X3) DATE SURVEY COMPLETED 01/30/2013

NAME OF PROVIDER OR SUPPLIER
SUMMIT VIEW OF LAKE CITY, LLC

SUMMARY STATEMENT OF DEFICIENCIES
(Each deficiency must be preceded by full regulatory or LSC identifying information)

(F371) Continued From page 10
was dented and should not be available for use.

Observation on January 28, 2013 at 7:00 a.m. of
the ice machine in the kitchen revealed a black
substance on the upper inside door of the ice
machine. Continued observation revealed the
reach-in cooler had a dried brownish substance
on the inside lower floor of cooler.

Interview with the Assistant Dietary Manager at
the time of the observations confirmed the ice
machine and reach-in cooler were dirty.

Observation and interview on January 29, 2013 at
10:20 a.m., in the kitchen revealed the sanitizing
compartment of the 3 compartment sink did not
have the required sanitation when tested with the
facility's testing strips.

Interview with the Certified Dietary Manager at
the time of the observation confirmed the rinse
water was not at the manufacturer's
recommended sanitization level.

Observation of the resident nourishment room
refrigerator during initial tour of the facility
January 28, 2013 at 4:20 a.m., in the east hall,
revealed 23 half undated sandwiches and 2
whole undated sandwiches, 1 open 1/2 pint
(236 ml) vitamin D milk, one 128 oz. container fruit
punch not dated, 4-1/2 pint fat free vitamin D
with A milk and 3-1/2 pint buttermilks out of date,
and all available for resident use.

Interview with Licensed Practical Nurse (LPN) #2
during the observation of the refrigerator
confirmed the undated and out-dated resident
nourishments.
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<tbody>
<tr>
<td>F 441 SS=D</td>
<td>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</td>
<td>F 441</td>
<td>1. The facility will maintain a sanitary environment and proper storage of linens. The food carts were covered by dietary staff. The linen in floor of linen storage room was sent to laundry by Housekeeping staff. <strong>1-28-15</strong></td>
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<td></td>
<td>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</td>
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<td>2. The food carts stored outside dietary will be covered by dietary or nursing staff as they are delivered to the dietary department. Nursing will alert dietary staff of the carts arrival and assist to cover cart. Housekeeping will check linen room every morning for any linen on the floor.</td>
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<td>(a) Infection Control Program</td>
<td></td>
<td>3. In-serviced dietary staff on sanitary environment on <strong>2-11-13</strong> by Dietary Manager to include storage of open tray carts in hallway. Housekeeping staff in-serviced on <strong>2-11-13</strong> by Housekeeping Supervisor to include proper storage of linen.</td>
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<td></td>
<td>The facility must establish an Infection Control Program under which it -</td>
<td></td>
<td>4. This will be monitored on a daily basis by Housekeeping staff or supervisor. Reviewed in month x4 Quality Assurance by Housekeeping Supervisor and Administrator.</td>
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<td>(1) Investigates, controls, and prevents infections in the facility;</td>
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<td>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</td>
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<td>(3) Maintains a record of incidents and corrective actions related to infections.</td>
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<td>(b) Preventing Spread of Infection</td>
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<td></td>
<td>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</td>
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<td>(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.</td>
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<td>(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.</td>
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<td>(c) Linens</td>
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<td>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</td>
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<td>F 441</td>
<td>Continued From page 12</td>
<td>F 441</td>
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<td>3-6-13</td>
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</table>

This REQUIREMENT is not met as evidenced by:

Based on observation, facility policy review, and interview, the facility failed to maintain a sanitary environment for three of five uncovered dirty food carts and failed to ensure proper storage of clean linens for one of three linen closets.

The findings included:

Observation on January 29, 2013 at 1:30 p.m., in the main hallway outside of the kitchen doors, revealed three uncovered food storage carts with uneaten food and open drink cartons on resident trays. Further observation revealed residents, facility staff and visitors passing by the uncovered carts.

Observation on January 30, 2013, at 7:55 a.m. and 1:15 p.m., in the main hallway outside the kitchen doors, revealed four food storage carts with uncovered, dirty resident food trays stored in the hallway.

Interview on January 29, 2013, at 1:35 p.m., with the dietary manager, in the main hallway outside of the kitchen doors, confirmed the food carts with dirty resident trays, were stored uncovered in the hallway. Further interview revealed "...just had not got to cover them up yet..."

Interview on January 29, 2013, at 1:45 p.m., with the corporate dietary manager, in the main hallway outside of the kitchen doors, confirmed the carts were uncovered and stored in the hallway. Further interview revealed "...this is where we store them because they will not fit in..."
### F 441: Continued From page 13

the wash area ...the staff move the carts into the wash area when they are ready for the next cart..."

Observation on January 28, 2013, at 4:35 a.m., in the East clean linen storage closet, revealed 4 blankets, 5 pillows, 12 bedspreads, and 2 gowns, on the floor.

Review of facility policy, Laundry and Linen Services states: "...Linen shall be handled, stored, and processed so as to control the spread of infection diseases..."

Interview with Licensed Practical Nurse (LPN) #2 during the observation confirmed the clean linen was on the floor, would no longer be considered clean, and should not be used for residents.

### F 456: ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION

The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview the facility failed to maintain essential equipment in safe operating condition.

The findings included:

Observation on January 28, 2013 at 7:00 a.m. in the walk-in cooler with the Assistant Dietary

1. The facility will maintain equipment in a safe operating condition. The walk-in freezer and steam table was cleaned by dietary staff and open wall seem repaired by maintenance on 2-1-13.

2. Sanitation report will be done by dietician or Dietary Manager on a weekly basis x4 and then monthly.

3. In-service on 2-11-13 by Dietary Manager to include equipment to be maintained in a safe operating condition and cleanliness.

4. This will be monitored by Dietician or Dietary Manager on a weekly basis and monthly in Quality Assurance by Dietary Manager.
<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>F 456</td>
<td>Continued From page 14</td>
<td>Manager revealed whitewash like substance on the right wall, black mold like substance on the left wall. Continued observation revealed an open well seam on the metal wall near the door. Continued observation revealed rust on the ceiling and around the door on the walls, and the floor littered with loose papers and empty containers. Continued observation of the walk-in freezer revealed the motor at the top of the freezer at the back wall dripping water on the floor and a thick layer of ice on floor. Interview with the Assistant Dietary Manager at the time of the observation, confirmed the equipment was not functioning properly. Observation on January 29, 2013 at 10:20, a.m., in the kitchen at the five well steam table with the Certified Dietary Manager, revealed five of the five compartments had floating debris in water and the bottom of the compartments was covered with rust. Interview with the Certified Dietary Manager at the time of observation, confirmed the steam table was not clean and was not properly maintained.</td>
<td>F 456</td>
<td>3-6-13</td>
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<tr>
<td>F 514</td>
<td>C/O TN-30719 483.75(f)(1) RES</td>
<td>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</td>
<td>F 514</td>
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The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.
The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation and interview, the facility failed to ensure an accurate medical record, related to medications, for one resident (#122) of ten residents reviewed during the medication administration.

The findings included:

Medical record review revealed resident #122 was admitted to the facility on October 12, 2011 with diagnoses including Severe Alcoholic Hepatitis, Urinary Tract Infection, Portal Hypertension, Depression, Hypokalemia (low potassium) and Hyponatremia (high blood sodium levels).

Medical record review of the Physician's Order Sheet, for January 1, 2013 through January 31, 2013, revealed "Propranolol Tab (Inderal) 40mg give ½ tablet (20mg) (milligrams) by mouth twice daily".

Observation on January 30, 2013 at 7:30 a.m., the 300 Hallway, during a random medication administration, with Licensed Practical Nurse (LPN) #6, revealed an order for Inderal LA 20mg (milligrams). Further observation revealed the
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Medication Administration Record (MAR) on the computer screen revealed "Inderal LA 60mg Twice daily 8 am and 8 pm 20mg, 1/3 tab". Continued observation revealed the medication in the medication cart was "...Propranolol (Inderal) 40mg, give ½ tablet (20mg) by mouth twice daily..."

Interview on January 30, 2013, at 7:30 a.m., in the 300 Wing Hallway, with LPN #6, confirmed the medication in the medication cart drawer was a "1/2 40 mg tablet of Inderal and the nurse stated "...was not sure why the computer MAR revealed Inderal 60 mg, give 1/3 tablet...will have to call the doctor..."

Interview on January 30, 2013, at 7:35 a.m. with the nurse manager of the unit, in the nurses' station, revealed "...the medications are put into the facility's computer system by the nurse...the only option we have is Inderal 60 mg...all the computer has is a 60 mg tablet option...there is not a 40 mg tablet option...we fax the physicians order sheet to the pharmacy and they put the medication into the medication record, fill the medication and send the medication to the facility...the resident received 20 mg of the Inderal..." Further interview with the nurse manager revealed "...it is confusing and...can see where this may be medication safety issue..."

Telephone interview on January 30, 2013, at 9:30 a.m., with the facility's consulting pharmacist, revealed "...we are aware of the incompatibility of two systems...since the Electronic Medication record has been in place...have had this issue...the facility faxes the physicians order sheet to the pharmacy and we enter the..."
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| F 514 | medication into the medication record, fill the medication and send the medications to the facility...the medication was started on March 14, 2012, and sent to the facility with 1/2 40 mg tablets of Inderal..." Further interview revealed"...they should have an option for the 40 mg tablet of Inderal...will call the computer representative today and find out what is going on and see what needs to be done to make the systems compatible..."

Interview on January 30, 2013, at 10:50 a.m., with the Director of Nursing (DON), in the DON office, confirmed the facility's medication record and the physician's order sheet did not match. Further interview revealed "...am aware of the medication issue...the facility's order and the pharmacy orders do not match...the pharmacist is aware and the facility is looking at options to update the computer system and make sure the systems are compatible...there is a meeting set up with the facility, the pharmacy and the computer representative for February 5, 2013...I see where this a potential issue..."