This Plan of Correction is the facility's credible allegation of compliance.

"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."

F155

1. The son of Resident #2 refuses recommended medical treatment. He does not attend Care Conferences. Most conversations with him are at the bedside or via telephone. On February 17, 2010, nurse's note reads, "Family refuses for resident to have PT/OT, wish is for comfort measures." On February 25, 2010 son refused hospice. On April 5, 2010 son refused a therapy screen of a
F 155  Continued From page 1
hygiene, and bathing). Medical record review of nurse's notes for May 6, 2010, revealed "r
(resident) L (left) hand c (with)
contractures-increased moisture r/t (related to)
contracture--will not refer to therapy d/t (due to)
comfort care/ family refuses..."

Continued medical record review revealed no documentation of a discussion with the son regarding the reasons for refusal of treatment and the medical contraindications for refusal of treatment.

Interview with LPN (Licensed Practical Nurse) #2 on July 28, 2010, at 1:30 p.m., in the Colonial Room, confirmed the medical contraindications for the refusal of treatment had not been discussed with the son.

F 176 483.10(n) RESIDENT SELF-ADMINISTER
DRUGS IF DEEMED SAFE

An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.

This REQUIREMENT is not met as evidenced by:
Based on observation, medical record review, facility policy review, and interview, the facility failed to assess a resident for self administration of medications for one (#21) resident of thirty-four residents reviewed.

The findings included:

Resident #21 was admitted to the facility on May 4, 2009, with diagnoses including Depressive
F 176: Continued From page 2

Disorder and Constipation.

Observation with LPN #3 on July 26, 2010, at 9:25 a.m., revealed the resident lying on the bed with the following on the overbed table:
- Mercurome, 16 ounce bottle approximately ½ full;
- Vapourub 1.75 ounce jar; Sterile eye drops, ½ fluid ounce approximately ¾ full;
- Orage! 0.42 ounce tube; Deep Sea Saline Spray, 1.5 fluid ounce, approximately ¾ full. Continued observation revealed the following on the table next to the bed: Desenex powder (Miconazole Nitrate 2%), 3 ounce bottle approximately ¼ full.

Review of the facility policy Self Administration of Medications revealed, "...Each resident who desires to self-administer medication is permitted to do so if the facility's interdisciplinary team has determined the practice would be safe for the resident and other residents in the facility...The interdisciplinary team determines the resident's ability to self-administer medications by means of a skills assessment..."

Interview on July 26, 2010, at 9:30 a.m., with LPN #3, at the 100 nursing station, confirmed the resident had not been assessed for self-administration of medications.

F 221: 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

This REQUIREMENT is not met as evidenced by:

F 176:

1. Resident # 21 was evaluated using the Medication Self-Administration Assessment. And was found to be capable of administering own medications.

2. Any resident who requests to administer his/her own medications will be assessed for safety of self-administration.

3. Any completed Medication Self-Administration Review will be evaluated by the Interdisciplinary Team for approval or non-approval of self-administration.

4. The Interdisciplinary Team's documented recommendation for self-administration will be presented by the Assistant Director of Nursing to the Performance Improvement Committee (Executive Director, Director of Nursing, Medical Director, Rehab Manager, Director of Social Services, Activity Director, Dietary Manager, Medical Records, and Pharmacy Consultant) meeting monthly for 6 months.
F 221: Continued From page 3

Based on observation, medical record review, and interview the facility failed to ensure one resident (#13) of thirty-four residents sampled remained free of physical restraint without medical symptom.

The findings included:

Medical record review revealed resident #13 was admitted to the facility July 24, 2010, with diagnoses including Urinary Tract Infection, Delirium, and Dementia.

Medical record review of the "Interim Care Plan" (not dated) revealed the use of restraints were not identified as an issue. Medical record review of a nurse's note dated July 24, 2010, revealed "SR (side rails) ^ (up) x 2 (times two).

Observation in the resident's room on July 26, 2010, at 9:15 a.m., revealed full side rails on each side of bed. Further observation revealed the resident positioned in a wheel chair with a self release belt. Observation revealed the resident unable to release the belt on command.

Interview on July 26, 2010, at 9:15 a.m., in the resident's room with a family member revealed the "full side rails were used the night of July 24, 2010, due to the resident's confusion."

Interview on July 27, 2010, at 2:45 p.m., with LPN #6 revealed the resident had attempted to exit the foot of the bed during the night on July 24, 2010.

Interview with the Director of Nursing in the conference room on July 29, 2010, at 8:30 a.m., confirmed the side rail and seat belt were used as a restraint without a medical symptom.

1. When Resident # 13 was admitted, bed and chair alarms were applied per facility policy. The full-length side rails were removed from the bed, and the self-release belt was removed from the wheelchair.

2. Residents will not have full-length side rails. Residents will be restrained only due to a medical condition, and with a physician's order.

3. Upon admission, residents will have bed and chair alarms for 72 hours while monitoring resident for fall risk. A fall risk assessment will be done as soon as possible after admission. If the resident is not at risk, the alarms will be removed. If the resident is at risk, the alarm, or other appropriate device, will be continued. Staff will be retrained on August 27, 2010. A make-up in-service Staff unable to attend this in-service.
F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation, facility policy review, and interview, the facility failed to promote dignity during care for two residents (#6 and #31) of thirty four residents reviewed and four rooms observed on initial tour.

The findings included:

Observation on the 300 hall, during the initial tour on July 26, 2010, at 9:15 a.m., revealed the medication nurse entering four resident rooms (#300, #302, #303, and #315) without knocking and requesting permission to enter. Interview with the nurse on July 26, 2010, at 10:00 a.m., confirmed permission was not requested to enter these rooms.

Resident #31 was admitted to the facility on May 15, 1974, with diagnoses including Mental retardation, Presenile Delusion, and Episodic Mood Disorder.

Observation on July 28, 2010, at 10:20 a.m., in the resident's room revealed Licensed Practical Nurse (LPN) #7 attempted to give the resident medications by mouth and the resident had a piece of chewing tobacco sticking out of the mouth. Continued observation revealed LPN #7
**NAME OF PROVIDER OR SUPPLIER**

**COLONIAL HILLS NURSING CENTER**

---

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.**

445181

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING

B. WING

**(X3) DATE SURVEY COMPLETED**

07/29/2010

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**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X6) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 241</td>
<td>Continued From page 5 without asking the resident's permission, with gloved hands pulled the piece of tobacco out, then used the index finger and swept through the resident's mouth to remove the remaining tobacco.</td>
<td>F 241</td>
</tr>
<tr>
<td></td>
<td>Interview with resident #31 on July 28, 2010, at 10:25 a.m., in the resident's room revealed the resident wanted the tobacco back and was not happy LPN #7 took the tobacco.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interview on July 28, 2010, at 10:28 a.m., in the hallway outside the resident's door with LPN #7 confirmed the LPN did not ask the resident's permission prior to removing the tobacco or asked the resident if the resident wanted more tobacco.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Resident #8 was admitted to the facility on February 8, 2010, with diagnoses including Hypertension, Chronic Pain, Bronchitis, and Depressive Disorder.</td>
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<tr>
<td></td>
<td>Medical record review of the Minimum Data Set dated May 20, 2010, revealed the resident had short term memory problems, no long term memory problems, and modified independence in cognitive skills for daily decision making.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Observation on July 28, 2010, at 9:50 a.m., revealed the resident sitting on the bed; the door to the resident's room open. Further observation revealed CNA (certified nursing assistant) #3, entered the resident's room without knocking on the door and asking permission prior to entering.</td>
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<tr>
<td></td>
<td>Review of facility policy Preservation of Residents' Rights revealed, &quot;...All associates are responsible for the preservation of residents' rights...Knocking</td>
<td></td>
</tr>
</tbody>
</table>

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1. LPN #7 works as needed (PRN). The Staff Development Coordinator on 8/19/2010 did a one-on-one training with LPN #7. The nurse was instructed to knock before entering any resident's room, to explain to the resident what she is there to do, and to ask resident #31 to remove his chewing tobacco so he can take his medicine. One-on-one training was done by the Staff Development Coordinator with CNA #3 on the importance of knocking and/or requesting permission to enter the room of Resident #6, or any resident's room.

2. Any resident has the potential to be affected.

3. Staff was in-serviced by the Executive Director and the Staff Development Coordinator on August 12, 2010. Education included the importance of respecting residents' privacy. Nursing staff will again be in-serviced on August 27, 2010, by the Director of Nursing on dignity and respect. Education will include advising resident of...
**NAME OF PROVIDER OR SUPPLIER**

COLONIAL HILLS NURSING CENTER

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
</table>
| F 241              | Continued From page 6 on doors and requesting permission to enter residents' rooms..."

Interview on July 28, 2010, at 9:50 a.m., at the 100 hall nursing station, with CNA (Certified Nursing Assistant) #3, confirmed the CNA did not knock on the resident's door and ask permission prior to entering the resident's room.

**F 246**

**483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES**

A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

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

Based on medical record review, observation, and interview, the facility failed to provide a call light within reach to allow one resident (#1) to seek assistance for care of thirty four residents reviewed.

The findings included:

Resident #1 was re-admitted to the facility on March 17, 2010, with diagnoses including Dementia with Behavior Disturbance, Urinary Tract Infection, Atrial Fibrillation (abnormal beats of the heart), and Brain Atrophy (shrinking of the brain).

Medical record review of the Minimum Data Set dated June 5, 2010, revealed the resident had...

F 241

what the caregiver is there to do, and asking permission. A make-up in-service will be scheduled for those staff members unable to attend.

4. **Staff Development**

Coordinator or designee will randomly monitor caregivers on each unit, and each shift, for compliance. Staff Development Coordinator will report findings to the Performance Improvement Committee (Executive Director, Director of Nursing, Medical Director, Rehab Manager, Director of Social Services, Activity Director, Dietary Manager, Medical Records, and Pharmacy Consultant) monthly for six months. Staff was in-serviced by the Executive Director and the Staff Development Coordinator on August 12, 2010. Education included importance of respecting residents' privacy by knocking on doors and requesting permission to enter their home.

Nursing staff will be in-serviced on August 27, 2010, by the Director of Nursing on dignity and respect. Education will include advising resident of what caregiver is there to do, and asking permission.
impairment in short and long-term memory, impaired decision making skills, required assistance with all activities of daily living, had a history of recent falls, and required a restraint daily to prevent further falls.

Observation on July 27, 2010, at 10:50 a.m., in the resident's room revealed the resident yelled "help, I want to go to bed my back hurts." Continued observation revealed the resident attempting to roll the wheelchair to the end of the bed where the call light was hanging off the footboard out of reach of the resident. Continued observation revealed the facility administrator and Certified Nurse Assistant (CNA) #4 entered the resident's room and moved the call light to the side of the bed where the resident could reach it.

Interview on July 27, 2010, at 10:53 a.m., with the facility administrator and CNA #4 confirmed the call light was hanging off the bed's footboard and the resident was unable to reach the call light to seek assistance to transfer to the bed.

F 248

483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES

The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, interview, and a review of facility provided documents, the facility failed to provide an ongoing program of activities on the Secure Unit.

F 246

1. Executive Director and Certified Nursing Assistant entered the room of Resident #1, and placed the call light within the reach of the resident.

2. Residents, especially those able to move about their room, have the potential to be affected.

3. Staff will be in-services on August 27, 2010, on the importance of the call light being within reach of residents. Monthly Staff in-services will include the importance of call lights being within reach.

4. Call light audits will be done on each shift weekly. The Assistant Director of Nursing will present the results to the Performance Improvement Committee (Executive Director, Director of Nursing, Medical Director, Rehab Manager, Director of Social Services, Activity Director, Dietary Manager, Medical Records, and Pharmacy Consultant) monthly for 12 months.
Continued From page 8

and failed to provide activities based on the specific assessed needs and interests of two residents (#26, #27) of thirty-four sampled residents.

The findings included:

Resident #26 was admitted to the facility on August 21, 2008, with diagnoses including Dementia, Depression, and Hypertension.

Medical record review of the Minimum Data Set (MDS), dated May 3, 2010, revealed the resident had short and long term memory impairment.

Medical record review of the Activity Assessment dated August 12, 2009, revealed the resident's preference was for daily activities, and the resident enjoyed parties, sing-a-longs, and shopping.

Review of the June 2010, Activity Log revealed the resident was not offered an activity twenty-one of thirty days.

Observation on July 27, 2010, at 9:20 a.m., 9:30 a.m., and 9:45 a.m., revealed the resident seated in a wheelchair in the secure unit dining room, with the face down almost touching the resident's breakfast plate. Observation on July 27, 2010, from 9:45 a.m., until 10:30 a.m., revealed the resident seated in the wheelchair in the secure unit dining room, dozing periodically, with no activities offered.

Observation on July 28, 2010, from 9:00 a.m., until 10:30 a.m., revealed the resident seated in the wheelchair in the secure unit dining room with no activities offered.

F 248 Activities Meet Needs of each Resident

1. One on One activity was given to resident #26 and #27 and will be offer to the residents three times a week.

2. On reviewing each residents on a quarterly bases, with the MDS the Activity Director will determine if the residents activity needs are being met or should be change to meet the residents needs.

3. The Activity Staff will be in-service on 8/24/2010 on how to maintain an activity schedule for the
<table>
<thead>
<tr>
<th>F 248</th>
<th>Continued From page 9</th>
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<tbody>
<tr>
<td>Interview with the Activities Director on July 29, 2010, at 8:55 a.m., in the private dining room, confirmed the resident was not offered an ongoing program of activities based on the resident’s needs and interests.</td>
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<tr>
<td>Resident #27 was admitted to the facility on May 1, 2009, with diagnoses including Alzheimer's Disease, Dementia with Behavioral Disturbance, and Hypertension.</td>
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<tr>
<td>Medical record review of the February 9, 2010, MDS, revealed the resident had short and long term memory impairment with severely impaired cognitive skills. Continued review of the MDS revealed the resident’s general activity preferences were games, exercise/sports, music, watching television, and conversing.</td>
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<tr>
<td>Review of the June 2010, Activity Log revealed the resident was offered an activity nineteen of thirty days.</td>
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<tr>
<td>Observation on July 27, 2010, from 9:30 a.m. until 10:30 a.m. in the secure unit dining room, revealed the resident seated at a table, continuously unbuckling the attached velcro self-release belt. Continued observation revealed the resident unbuckled the belt, waited for nursing staff to come to close the belt, then the resident would unbuckle the belt again after about thirty seconds. Continued observation revealed this process was continuously repeated, and no diversional activities were offered to the resident.</td>
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<tr>
<td>Interview with the Activities Director on July 29, 2010, at 6:58 a.m., in the private dining room, confirmed the resident was not offered an activity to the residents on the secure unit. The activity department will offer an activity to the residents after 4:00 p.m. 2 days a week and activities once a month on the weekends to the secure unit. The Activity Director will audit the activity calendar to ensure that the activity schedule is being met.</td>
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<tr>
<td>4. The Activity Director will monitor the progress of the changes and report the results to the Performance Improvement Committee (Executive Director, Director of Nursing, Medical Director, Rehab Manager, Director of Social Services, Activity Director, Dietary Manger, Medical Records, and Pharmacy Consultant) for three months.</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**COLONIAL HILLS NURSING CENTER**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</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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</thead>
<tbody>
<tr>
<td>F 248</td>
<td>Continued From page 10 ongoing program of activities based on the resident's needs and interests.</td>
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<tr>
<td></td>
<td>Observation on the Secure Unit on July 27, 2010, from 9:20 a.m. until 11:00 a.m., and on July 28, 2010, from 9:30 a.m. until 10:45 a.m., revealed no activity offered to several residents who were seated in the Secure Unit dining room with nothing to do. Observation on the Secure Unit on July 28, 2010, at 8:00 p.m., revealed several residents in the dining room, sitting with no activity offered.</td>
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<td></td>
<td>Interview with LPN (Licensed Practical Nurse) #6 (unit manager for the secure unit) on July 28, 2010, at 10:45 a.m., in the secure unit dining room, revealed no activities are offered after 3:00 p.m., in the evening and on the weekend no activities are offered on the secure unit.</td>
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<td>Review of facility provided documents and interview with the Activities Director on July 29, 2010, at 9:00 a.m., in the private dining room, revealed four of twenty-eight residents on the secure unit leave the unit on the weekends to attend church services in the main dining room. Continued interview with the Activities Director on July 29, 2010, at 9:02 a.m., in the private dining room, confirmed residents on the secure unit are not offered activities after 4:00 p.m. in the evening, or on the weekends, unless they go off (the unit) for weekend activities in the main dining room.</td>
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<tr>
<td>F 280</td>
<td>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</td>
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<td>The resident has the right, unless adjudged incompetent or otherwise found to be</td>
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| F 280         | Continued From page 11  
incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. 
A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. 

This REQUIREMENT is not met as evidenced by: 
Based on medical record review, observation and interview the facility failed to revise the care plan to address the current status for three (#4, #14, and #21) of thirty-four residents reviewed. 
The findings included: 
Resident #4 was admitted to the facility on October 20, 2008, with diagnoses including Failure to Thrive, Osteoporosis, and Dysphagia. 
Observation in the resident's room on July 26, 2010, at 9:30 a.m., revealed specific aspiration precautions (choking prevention) posted in room. Medical record review of the comprehensive care plan dated as reviewed on July 11, 2010, revealed the aspiration precautions were not |
| F 280         | 1. Resident #4's Care Plan has been updated to include aspiration precautions as an intervention. Resident #14's Care Plan has been updated to address the use of a lap tray on her wheelchair. Resident #21's Care Plan has been updated to show that even though the Bowel and Bladder Assessment indicates she is a candidate for toileting, the resident is bedfast and refuses to use the bedpan. 
2. Residents with Care Plans have the potential to be affected. 
3. Unit Managers will be a part of the Interdisciplinary Team Care Conferences held for residents on their respective units. 
4. Ten percent of Care Plans will be randomly audited every month, and results of the audits will be reported to the Performance Improvement Committee (Executive Director, Director of Nursing, Medical Director, Rehab Manager, Director of Social Services, Activity Director, Dietary Manager, Medical Records, and Pharmacy Consultant by the RN MDS Coordinator monthly for 12 months. |
| 07/29/2010    |                                                                                                 |               |                                                                                                 |                |
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

### (X1) PROVIDER/SUPPLIER/LIA

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<th>ID</th>
<th>PROVIDER/SUPPLIER/LIA IDENTIFICATION NUMBER</th>
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### (X2) MULTIPLE CONSTRUCTION

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### (X3) DATE SURVEY COMPLETED

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<tr>
<th>DATE</th>
<th>07/29/2010</th>
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**NAME OF PROVIDER OR SUPPLIER**

**COLOMBIA HILLS NURSING CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

2034 COCHRAN RD
MARYVILLE, TN 37803

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<thead>
<tr>
<th>(X4) ID</th>
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<th>(X5) COMPLETION DATE</th>
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<tr>
<td>F 280</td>
<td>Continued From page 12 included as interventions.</td>
<td>F 280</td>
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</table>

Interview with the Director of Nursing on July 28, 2010, at 8:30 a.m., in the conference room confirmed the care plan was not revised to reflect the resident's current care needs.

Resident #14 was re-admitted to the facility on December 28, 2010, with diagnoses including Congestive Heart Failure, Depressive Disorder, and Dysphagia. Medical record review revealed a physician's order dated June 4, 2010, for use of lap tray on wheelchair.

Review of facility Physical Restraint Assessment revealed "Physical restraint used...tray table in wheelchair." Medical record review of the comprehensive care plan revealed no plan for the use of a physical restraint.

Interview with the Director of Nursing in the conference room on July 28, 2010, confirmed the care plan failed to address restraint use.

Resident #21 was admitted to the facility on May 4, 2009, with diagnoses including Depressive Disorder and Constipation.

Medical record review of the Minimum Data Set dated May 13, 2010, revealed the resident had no short/long term memory problems, modified independence in cognitive skills for daily decision making, and incontinent of bowel and bladder.

Medical record review of the Assessment for Bowel and Bladder Training dated June 16, 2010, revealed the resident was a candidate for toileting, timed, or scheduled voiding.

Interview on July 29, 2010, at 8:20 a.m., with CNA...
## statement of deficiencies and plan of correction

### COLONIAL HILLS NURSING CENTER

<table>
<thead>
<tr>
<th>(X4) ID</th>
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</tr>
</thead>
<tbody>
<tr>
<td>F 280</td>
<td>Continued From page 13 #5, at the 100 hall nursing station, confirmed the resident refused to use the bedpan.</td>
<td></td>
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<tr>
<td></td>
<td>Interview on July 29, 2010, at 8:40 a.m., in the conference room, with the DON (Director of Nursing) confirmed the resident's refusal to use a bedpan was not on the careplan.</td>
<td></td>
</tr>
<tr>
<td>F 281</td>
<td>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.</td>
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<tr>
<td></td>
<td>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow or obtain physician's orders for medication and equipment for two residents (#10, #3) and failed to correctly implement feeding instructions for one resident (#2) of thirty-one sampled residents.</td>
<td></td>
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<td></td>
<td>The findings included: Resident #10 was admitted to the facility on March 17, 2009, and re-admitted on July 23, 2010, with diagnoses including Diabetes Mellitus, End Stage Renal Disease on Dialysis, Congestive Heart Failure, and Dementia.</td>
<td></td>
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<td>Medical record review of the Nursing Care Facility Admission Orders dated July 23, 2010 revealed, &quot;...Insulin Regular Human Recombinant (Novolin R) Subcutaneous (injection) AC and HS (before meals and at bedtime)...Blood Glucose: 71-150=0 units; 151-200=2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; (under 70 or over 350 = call MD)...&quot;</td>
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### F 280
Resident #10's LPN was retrained by the Staff Development Coordinator on July 27, 2010, on determining the amount of insulin needed via sliding scale. Resident #3 was re-admitted with no order for a multipod boot. The boot remained from previous admission and was applied in error. Multipod boot was removed from the room. Resident #2's feeding instructions have been added to care guides along with how bed is to be positioned during feeding.
F 281 Continued From page 14

Medical record review of the July 2010 Medication Administration Record (MAR) starting July 23, 2010, revealed, "... Accuchecks (blood glucose checks) 6:30 a.m., 4:30 p.m., results 200-250 2 units, 251-300 4 units, 301-350 6 units, 351-400 8 units, > 400 call MD..." Continued review of the MAR revealed the resident's blood glucose was checked at 6:30 a.m., and 4:30 p.m., (not before the lunch meal and not at bedtime as ordered). Continued review of the MAR revealed July 24, at 4:30 p.m., the resident's blood glucose was 196, and no insulin was administered; July 25, 2010, at 6:30 a.m., the resident's blood glucose was 180, and no insulin was administered; July 25, at 4:30 p.m., the resident's blood glucose was 242, and 2 units of insulin were administered (4 units were ordered); July 26, 2010, 6:30 a.m., the blood glucose was 174, and no insulin was administered; July 27, at 4:30 p.m., the resident's blood glucose was 195, and no insulin was administered; and on July 28, at 6:30 a.m., the resident's blood glucose was 159, and no insulin was administered.

Interview with LPN (Licensed Practical Nurse) #2 on July 28, 2010, at 3:00 p.m., in the 400 Hall Nurse's station confirmed the sliding scale Insulin orders on the resident's Medication Record did not match the facility Admission Orders of July 23, 2010.

Resident #3 was admitted to the facility on December 22, 2009, with diagnoses including Cerebrovascular Accident, Hypertension, Dysphagia, and Peripheral Arterial Disease.

Observation on July 26, 2010, at 1:30 p.m. and July 28, 2010, at 10:45 a.m., revealed the
**ORTHOMEDICAL HILLS NURSING CENTER**

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 281</td>
<td>Continued From page 15</td>
<td>F 281</td>
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<tr>
<td></td>
<td>resident sitting in the wheelchair with a multipodus boot on the left lower extremity.</td>
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<tr>
<td></td>
<td>Medical record review of the July, 2010, physician's orders revealed no order for the multipodus boot.</td>
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<td></td>
<td>Interview on July 28, 2010, at 10:40 a.m., with RN (Registered Nurse) #1, at the 300 nursing station, confirmed the facility had failed to obtain a physician's order for the multipodus boot.</td>
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<td></td>
<td>Resident #2 was admitted to the facility on January 25, 2007, with diagnoses including Adult Failure To Thrive, End Stage Dementia, and Dementia with Behavioral Disturbances.</td>
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<td></td>
<td>Observation on July 26, 2010, at 8:30 a.m., revealed the resident in bed with a sign over the bed for feeding instructions due to aspiration (chooking) precautions, and signed by the speech therapist. Continued observation revealed when feeding the resident, the staff were to alternate solids and liquids, and the resident's bed was to be positioned at a ninety degree angle.</td>
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<td>Observation on July 27, 2010, at 1:05 p.m., revealed while feeding the resident, CNA #5 was feeding the resident two spoonfuls of food before offering a liquid, and the resident's head of bed was elevated to forty-five degrees.</td>
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<td>Interview on July 27, 2010, at 1:30 p.m., in the Colonial Room, with LPN #6 confirmed the speech therapy instructions for feeding were not correctly implemented.</td>
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<td>F 315</td>
<td>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</td>
<td>F 315</td>
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</table>
Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to provide incontinence care to prevent contamination for one resident (#1) of thirty-four residents reviewed.

The findings included:
Resident #1 was re-admitted to the facility on March 17, 2010, with diagnoses including Dementia with Behavior Disturbance, Urinary Tract Infection, Atrial Fibrillation (abnormal beats of the heart), and Brain Atrophy (shrinking of the brain).

Medical record review of the Minimum Data Set dated June 5, 2010, revealed the resident had impaired short and long term memory, impaired decision making skills, required assistance with all activities of daily living, had a history of recent falls, and required a restraint daily to prevent further falls.

Observation on July 27, 2010, at 10:55 a.m., in the resident's room revealed Certified Nurse
F 315: Continued From page 17

Assistant (CNA) #4 providing the resident with incontinence care. Continued observation revealed the resident was incontinent of urine and feces. CNA #4 removed the soiled brief; used a washcloth wet with water, and washed the resident's groin with a back and forth motion, without retracting the foreskin and cleansing the penis head. Continued observation revealed CNA #4 assisted the resident to turn over onto the right side and with the same washcloth removed the feces from the rectum and washed the anal area and buttocks in a side to side motion.

Interview on July 27, 2010, at 11:00 a.m., in the resident's room with CNA #4 confirmed the CNA washed the groin area with a back and forth motion, did not retract the resident's foreskin to check for feces, and used the same washcloth and removed feces, and washed the resident's buttocks with a side to side motion.

Interview on July 28, 2010, at 10:00 a.m., with the Registered Nurse Staff Development/Infection Control Nurse in the 400 hallway confirmed incontinence care for a un-circumcised male requires the foreskin to be retracted and the area cleansed especially after incontinence of feces, and the groin area is to be washed in a front to back motion to prevent contamination.

F 323: 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.
This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation, and interview, the facility failed to provide safety interventions for two residents (#22, #16), failed to ensure a safety device was in place for one (#7) resident and failed to provide safe storage of sharp objects for one (#9) resident of thirty-four residents reviewed.

The findings included:

Resident #22 was re-admitted to the facility on August 24, 2009, with diagnoses including History of Hip Fracture and repair, Difficulty Ambulation, and Psychosis.

Medical record review of the Minimum Data Set dated July 7, 2010, revealed the resident had impaired short and long term memory, impaired decision making skills, required assistance with transfers, was non-ambulatory, and required assistance with all activities of daily living.

Medical record review of the July 2010, physician orders revealed "...bed and w/c (wheel chair) alarms D/T (due to) decreased safety awareness..."

Observation and interview, on July 27, 2010, at 1:45 p.m., in the 300 hallway revealed the resident sitting in the wheelchair with a tab alarm box applied to the back rest and the clip not attached to the resident. Interview with Registered Nurse #2 at that time confirmed the clip for the tab alarm was not attached to the
**STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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</thead>
<tbody>
<tr>
<td>F 323</td>
<td>Continued From page 19</td>
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<tr>
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<td>resident to alert the staff if the resident attempted to self transfer.</td>
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<tr>
<td></td>
<td>Observation and interview on July 27, 2010, at 6:50 p.m., with Certified Nurse Assistant (CNA) #4 revealed the pressure pad alarm for the resident's bed in place with the pressure pad alarm cord wrapped around the side rail; the box for the pressure pad alarm was on the bedside table without the pressure pad alarm cord plugged into the alarm box (enabling the alarm to sound if the resident attempted to climb out of the bed). Interview at that time revealed the cord would not stay plugged into the box and CNA #4 had not obtained a new alarm system to alert staff if the resident attempted to climb out of the bed.</td>
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<tr>
<td></td>
<td>Resident # 16 was re-admitted to the facility on April 7, 2009, with diagnoses including Dementia, Mental Retardation, Peripheral Vascular Disease, Diabetes Mellitus, Bilateral Below The Knee Amputation, and Depression.</td>
</tr>
<tr>
<td></td>
<td>Medical record review of a Smoking Safety Assessment dated March 9, 2010, listed interventions as &quot;...Staff in attendance during all smoking times...&quot; and &quot;...Smoking apron...&quot;</td>
</tr>
<tr>
<td></td>
<td>Medical record review of the Care Plan updated June 6, 2010, included &quot;...smokes and is at safety risk...Approaches included...Smoking apron when smoking...&quot;</td>
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<tr>
<td></td>
<td>Medical record review of the Physician Recapitulation Orders for July 2010, revealed &quot;...Safety devices are in place per Plan of Care...&quot;</td>
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<td></td>
<td>Observation on July 27, 2010, at 9:00 a.m., and 10:00 a.m., in the outside designated smoking</td>
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<thead>
<tr>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION</th>
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<tbody>
<tr>
<td>F 323</td>
<td>3. On August 27, 2010, the Restorative Nurse will instruct the staff on proper application and use of safety devices for residents. These will include all types of alarms, smoking aprons, and other safety devices. The Staff Development Coordinator will remind staff of the importance of an admission inventory being done, and the importance of the nurse ensuring that the newly-admitted resident does not have items which might pose a danger to himself or others. The Restorative Nurse will do random audits weekly to ensure safety devices are being used correctly. Three times a week the Central Supply Manager will continue to audit alarms for placement, and to change batteries as needed.</td>
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<td>4. The Director of Nursing will present the results of the random audits and the Central Supply Manager's audits to the Performance Improvement Committee (Executive Director, Director of Nursing, Medical Director, Rehab Manager, Director of Social Services, Activity Director, Dietary Manager, Medical Records, and Pharmacy Consultant) monthly for three months.</td>
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<tr>
<th>STRENGTHS:</th>
<th>CAVITY:</th>
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<td>- No active strengths found.</td>
<td>- No active caveats found.</td>
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9/1/2010
**NAME OF PROVIDER OR SUPPLIER**

**COLONIAL HILLS NURSING CENTER**

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<table>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 323</td>
<td>Continued From page 20 area, revealed the resident smoking with a staff attendant present and no smoking apron on the resident.</td>
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<tr>
<td></td>
<td>Interview with LPN #1 on June 27, 2010, at 1:10 p.m., outside of the resident's room, confirmed the resident required a smoking apron when smoking.</td>
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<td>Resident #7 was admitted to the facility on November 8, 2005, with diagnoses including Aphasia, Hypertension, Depressive Disorder, and Tachycardia.</td>
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<td>Medical record review of a falls risk evaluation dated June 18, 2010, revealed the resident was at risk for falls.</td>
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<td>Medical record review of the careplan dated July 15, 2010, revealed, &quot;...8/26/09 Pressure alarm to bed...Clip alarm in w/c (wheelchair)...&quot;</td>
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<td>Review of a facility investigation dated June 7, 2010, revealed the resident was found on the floor on both knees after standing up out of bed, alarm unplugged, and no injury.</td>
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<td>Interview on July 28, 2010, at 4:30 p.m., with LPN #4, in the conference room, confirmed the alarm was not plugged in on the June 7, 2010, fall.</td>
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<td>Observation with LPN #3, on July 27, 2010, at 8:30 a.m., in the resident's room, revealed the resident sitting in the wheelchair with the clip alarm not attached to the resident. Interview at this time with LPN #3 confirmed the clip alarm was not attached to the resident.</td>
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<td></td>
<td>Observation with the DON (Director of Nursing)</td>
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<td>ID</td>
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<td>TAG</td>
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<td>F323</td>
<td>Continued From page 21</td>
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<td>on July 28, 2010, at 9:00 a.m., revealed the resident sitting in the wheelchair, in the hallway, with the clip alarm not attached to the resident. Interview at this time with the DON confirmed the clip alarm was not attached to the resident.</td>
<td>F323</td>
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<td>Resident #9 was admitted to the facility on July 21, 2010, with diagnoses including Chronic Tracheostomy, Pneumonia with MRSA (contagious infection), and PEG Tube (tube inserted into the stomach for feeding).</td>
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<td>Observation and interview with Registered Nurse (RN) #2 in the resident's room. On July 26, 2010, at 9:55 a.m., revealed a basin on the desk with the following: four razors, two Intravenous Catheters; one scissor, and one large tweezers. Interview at that time with RN #2 confirmed the razors, Intravenous Catheters, scissor, and tweezers, were sharp items and were accessible to confused residents.</td>
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<tr>
<td>F332</td>
<td>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</td>
<td></td>
<td>The facility must ensure that it is free of medication error rates of five percent or greater.</td>
<td>F332</td>
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</tbody>
</table>
The findings included:

Resident #9 was admitted to the facility on July 21, 2010, with diagnoses including Chronic Tracheostomy, Pneumonia with MRSA (contagious infection), Hypertension, History of Colon Cancer, Hypothyroidism, and PEG Tube (tube inserted into the stomach for feeding).

Medical record review of the physician’s orders for July 2010, revealed "...Lortab Elixir (liquid) 7.5/500 mg (milligrams) give 10 ml (milliliter) BID per tube 8 am 8 pm (for pain)...Synthroid 225 mcg (micrograms) (needs to be given at the same time everyday) per tube every day 8 am...and Norvasc 10 mg once daily per tube (for high blood pressure)...."

Observation on July 27, 2010, from 9:50 a.m., to 10:00 a.m., in resident #9's room, revealed Licensed Practical Nurse (LPN) #1 administered per the resident’s PEG Tube: Lortab 10 ml, Synthroid 200 mcg (200mcg was ordered), and Norvasc 5 mg (10 mg was ordered).

Interview and review of the physician’s orders on July 27, 2010, at 9:30 a.m., outside of resident #9’s room with LPN #1 confirmed: Synthroid 200 mcg was administered to the resident and the physician ordered 225 mcg; Norvasc 5 mg was administered to the resident and the physician ordered 10 mg, the three medications were scheduled to be administered at 8:00 a.m., and the medications were administered at 10:00 a.m., two hours after the ordered time.

Resident #14 was admitted to the facility on December 28, 2009, with diagnoses including...
Continued From page 23

Psychosis, Constipation, Hypertension, and Dementia.

Medical record review of the physician's July 2010, orders revealed: "...Benztropine 2 mg tablet, one po (by mouth) BID (for Parkinson's disease and needs to be given at the time ordered to maintain a steady level in the blood)...Namenda 10 mg tablet, one po BID (for memory and needs to be given at the time ordered to maintain a steady level in the blood)...Restasis OPTH. (eye) solution, 1 gtt (drop) both eyes BID (helps eyes to make tears and needs to be given at the time ordered to maintain a steady level in the blood)...Depakote 125 mg Sprinkle 2 caps (capsules) po BID (for behavior and needs to be given at the time ordered to maintain a steady level in the blood)...Metoprolol Tartrate 25 mg tab, 1 tablet po daily (for high blood pressure and needs to be given at the time ordered to maintain a steady level in the blood)..."

Observation on July 27, 2010, at 10:20 a.m., in resident #14's room revealed LPN #6 administered three Restasis drops into the resident's left eye, one Namenda 10 mg tablet, one Benztropine 2 mg tablet, one Metoprolol 25 mg, and two Depakote 125 mg Sprinkle 125 mg capsules.

Interview and review of the physician's orders with LPN #6 on July 27, 2010, at 10:35 a.m., at the A-wing nurse's desk confirmed two drops of Restasis eye drops were administered into the resident's left eye and the physician ordered one drop in each eye, and all four medications were scheduled at 8:00 a.m., and were administered at 10:20 a.m., over two hours after the scheduled...
**Resident #31** was admitted to the facility on May 15, 1974, with diagnoses including Mental Retardation, Presenile Delusion, and Episodic Mood Disorder.

Medical record review of the physician orders for July 2010, revealed "...Depakote Sprinkle caps give 6, 125 mg caps to equal 750 mg po three times per day (for Episodic Mood Disorder and needs to be given at the time ordered to maintain a steady level in the blood)..."

Observation on July 28, 2010, at 10:15 a.m., in resident #31's room revealed LPN #7 administered 6 Depakote 125 mg capsules to the resident.

Interview on July 28, 2010, at 10:30 a.m., outside of resident #31's room, confirmed the Depakote was administered over two hours after the scheduled time of 8:00 a.m.

**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*
F 371. Continued From page 25

by:

Based on observation and interview the facility failed to store prepare and serve food in a sanitary manner.

The findings included:

Observation in the kitchen on July 26, 2010, at 9:10 a.m., July 27, 2010, at 11:00 a.m., and 2:00 p.m. revealed the following:

1. Hamburger patties at 130 degree F. and reheated to 152 degree F. (Beef must be reheated to 165 degree).
2. Custard type cheese pie served at 50 degree. (Cold food must be served at or below 40 degree).
3. Custard type pureed dessert at 60 degree.
4. Three dietary employees on serving line with hair not completely contained.
5. Manual can opener dirty.
7. Broken door gasket in walk in cooler.

Interview with the dietary manager in the main dining room on July 28, 2010, confirmed the above findings.

F 431

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.

F 431

2. The dietaries was in-service on the checking of the food temperatures at the beginning of the tray line and again in the middle of the tray line to ensure the proper temperatures are being maintain. The manual can opener will be clean twice a month or as needed. The convection oven will be clean twice a month or as needed. The door gasket in the walk in cooler will be monitor monthly.

3. The cook will record the temperatures in the temperature log. The dietary Manager or Assistance Dietary Manager will monitor the temperature log on daily bases to ensure accuracy of the food temperatures.

4. The Dietary Manager or designee will report the results to the Performance Improvement Committee (Executive Director, Director of Nursing, Medical Director, Rehab Manager, Director of Social Services, Activity Director, Dietary Manager, Medical Records, and Pharmacy Consultant) for three months.
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 quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation, and interview, the facility failed to provide safe storage of medications for two residents (#9, #21) of thirty-four residents reviewed.

The findings included:

Resident #9 was admitted to the facility on July 21, 2010, with diagnoses including Chronic Tracheostomy, Pneumonia with MRSA (contagious infection), and PEG Tube (tube inserted into the stomach for feeding).
Observation and interview with Registered Nurse (RN) #2 in the resident's room, on July 26, 2010, at 9:55 a.m., revealed a basin on the desk with the following: one 12 ounce Fleets enema; one 16 ounce bottle of Hydrogen Peroxide, ¼ full; and one 1.5 ounce bottle of Toothpaste Oral Care (has hydrogen peroxide) ½ full. Interview at that time with RN #2 confirmed the medications were not stored to prevent access for confused residents.

Observation on July 27, 2010, at 9:50 a.m., outside of resident #9's room revealed a medication cart unlocked and unattended. Continued observation revealed: one 24 ounce bottle of Miralax (powdered laxative); one 100 mg (milligram) tablet of Colace (stool softener); one tablet of Flora Q Probiotic (dietary supplement), 10 milliliters of hydrocodone/acetaminophen 75/500 (narcotic pain medication), one tablet levothyroxine (thyroid medication) 200 mg, and one tablet Norvasc (blood pressure medication) 5mg. Continued observation revealed LPN #1 was in resident #9's bathroom and out of direct sight of the medication cart.

Interview on July 27, 2010, at 9:52 a.m., outside of resident #9's room with Licensed Practical Nurse (LPN) #1 confirmed the medication cart was unlocked, resident #9's medications and a bottle of Miralax were left on top of the cart and the medication cart and the medications were not within direct sight to prevent unauthorized access.

Resident #21 was admitted to the facility on May 4, 2009, with diagnoses including Depressive Disorder and Constipation.

Observation with LPN #3 on July 26, 2010, at
**NAME OF PROVIDER OR SUPPLIER**

**COLONIAL HILLS NURSING CENTER**

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<tr>
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<td>F 431</td>
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<td>Continued From page 28</td>
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<tr>
<td>F 441</td>
<td>SS</td>
<td>483.65 INFECTION CONTROL, PREVENT</td>
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<td>SPREAD, LINENS</td>
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**STREET ADDRESS, CITY, STATE, ZIP CODE**

**2034 COCHRAN RD**

**MARYVILLE, TN 37803**

**DATE SURVEY COMPLETED**

07/29/2010

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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER.</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<td>445181</td>
<td>A. BUILDING</td>
<td>07/29/2010</td>
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<td>B. WING</td>
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**F 431**: Continued From page 28

9:25 a.m., revealed the resident lying on the bed with the following on the overbed table:
- Mercuchrome, 16 ounce bottle approximately ½ full
- Vapomurub 1.75 ounce jar
- Sterile eye drops ½ fluid ounce approximately ½ full
- Oragel 0.42 ounce tube
- Deep Sea Saline Spray, 1.5 fluid ounce, approximately ¼ full
- Observation revealed the following on the table next to the bed: Deserex powder (Miconazole Nitrate 2%, 3 ounce bottle approximately ¼ full).

Interview on July 26, 2010, at the 100 hall nursing station, with LPN #3, confirmed the medications are not to be at the bedside.

**F 441**: 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

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.

(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
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2. Residents with clean or sterile treatments have the potential to be affected.

3. Staff will be in-serviced on August 27, 2010 on infection control issues such as the care of a tracheostomy. Hand washing during medication delivery, hand-washing when removing gloves, and timely cleaning of equipment. A make-up in-service will be scheduled for staff unable to attend.

4. The Staff Development Coordinator or designee will randomly monitor staff on all units and all shifts, for appropriate techniques for infection control. Results of audits will be reported to the Performance Improvement Committee (Executive Director, Director of Nursing, Medical Director, Rehab Manager, Director of Social Services, Activity Director, Dietary Manager, Medical Records, and Pharmacy Consultant) monthly for three months.

(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 review, observation, review of facility policy/procedure, and interview, the facility failed to provide care in a sanitary manner for four residents (#9, #14, #3, #2) of thirty-four residents reviewed.

The findings included:

Resident #9 was admitted to the facility on July 21, 2010, with diagnoses including Chronic Tracheostomy, Pneumonia with MRSA (contagious infection), Hypertension, History of Colon Cancer, Hypothyroidism, and PEG Tube (tube inserted into the stomach for feeding).

Observation on July 27, 2010, at 9:50 a.m., in the resident’s room revealed the resident’s inner cannula (tube inside of the outer appliance to keep the Tracheostomy open) was dropped on the floor by LPN (Licensed Practical Nurse) #1. Continued observation revealed LPN #1 picked up the cannula and without using the special
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cannula brush, washed it in the bathroom sink with hand soap and tap water; rinsed it with tap water; and gave the inner cannula to the resident who placed it into the outer appliance of the tracheostomy. Continued observation revealed the resident gave LPN #1 another inner cannula to clean; LPN #1 without using the special cannula brush, washed it in the bathroom sink with hand soap and tap water; rinsed it with tap water; wrapped it in paper towel and gave it to the resident who placed it on the over the bed table.

Observation on July 27, 2010, at 10:45 a.m., in the resident's room revealed the resident handed LPN #1 an inner cannula; LPN #1 without using the special cannula brush, washed it in the bathroom sink with hand soap and tap water; rinsed it with tap water; and placed it in a paper towel and handed it to the resident who placed it on the over the bed table.

Review of the facility's Tracheostomy Care Policy revealed "...Purpose: To provide a clean method of cleaning the tracheostomy site and a sterile method of cleaning/replacing the inner cannula. Remove the inner cannula and place in the hydrogen peroxide. Use the brush to clean the inner cannula. Rinse the inner cannula by agitating it in the sterile water. Dry the inner cannula with sterile gauze and pipe cleaners. Set the inner cannula on the sterile drape."

Interview on July 28, 2010, at 7:50 a.m., with the Registered Nurse in charge of staff development and infection control confirmed resident #5's inner cannula was washed with hand soap and tap water, and the appropriate procedure is to use hydrogen peroxide and sterile water with a special brush to prevent further respiratory infections.
Resident #14 was admitted to the facility on December 28, 2009, with diagnosis including Dementia.

Observation on July 27, 2010, at 10:00 a.m., outside of the resident's room and continued into the resident's room, revealed LPN #6 touched the lid for the trash bin on the medication cart, and without washing or sanitizing the hands administered the resident's medications with a spoon.

Interview on July 27, 2010, at 10:35 a.m., with LPN #6 at the A-wing nurse's desk confirmed the LPN touched the trash bin on the medication cart, and without washing or sanitizing the hands administered the resident's medications with a spoon.

Resident #3 was admitted to the facility on December 22, 2009, with diagnoses including Cerebrovascular Accident, Hypertension, and Peripheral Arterial Disease.

Observation of a dressing change on July 27, 2010, at 10:50 a.m., with LPN treatment nurse #1, revealed the following: Applied gloves; measured the wound on the left heel; cleansed the wound on the left heel; removed the gloves and applied new gloves without washing the hands; applied the skin prep around the wound; applied the sanyt to the wound using a sterile q-tip; applied a dressing to the wound on the left heel; removed gloves, and washed the hands with soap and water.

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Management revealed, "...Cleanse wound as directed...Remove gloves and discard in disposable bag...Wash hands...Apply new gloves..."

Interview on July 27, 2010, at 11:05 a.m., with LPN #1 treatment nurse, on the 300 hall, confirmed the hands were not washed after cleaning the wound, removing the gloves and applying new gloves.

Resident #2 was admitted to the facility on January 25, 2007, with diagnoses including Depression, Peripheral Vascular Disease, and Atrial Fibrillation.

Observation of a dressing change on July 28, 2010, at 10:05 a.m., with LPN treatment nurse #1, revealed the following: Cut the dressing off of the right foot wound using scissors, and put the scissors in his/her pocket without cleaning.

Interview on July 28, 2010, at 10:35 a.m., with LPN treatment nurse #1, on the 200 hall, confirmed the scissors were not cleaned after removing the dressing from the wound and placing in the pocket.

F 502 483.75(j)(1) PROVIDE/OBTAIN LABORATORY

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

1. Resident #1 will have INR done as ordered by the physician.
2. Residents taking Coumadin have the potential to be affected.
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facility failed to obtain laboratory tests as ordered for one resident (#1) of thirty-four residents reviewed.

The findings included:

Resident #1 was re-admitted to the facility on March 17, 2010, with diagnoses including Dementia with Behavior Disturbance, Urinary Tract Infection, Atrial Fibrillation (abnormal beats of the heart), and Brain Atrophy (shrinking of the brain).

Medical record review of the physician's order dated May 27, 2010, revealed "...recheck INR (test for speed of blood clotting) 6-1-10..."

Medical record review of the laboratory test results failed to reveal results for the physician ordered INR for June 1, 2010. Medical record review of the laboratory test results revealed results for an INR drawn on June 3, 2010, of 3.1 (normal values are 2.0-3.0) and with new physician's orders to decrease the dosage of Coumadin to 5 milligrams daily and to repeat the INR in one week.

Interview on July 29, 2010, at 8:55 a.m., in the library with the director of nursing revealed the June 1, 2010, INR was not obtained as the physician ordered until June 3, 2010, (two days late).

Medical record review of the INR test dated July 9, 2010, revealed results of 3.9 (above the 2.0-3.0 normal value) with physician’s order to hold the Coumadin until Monday July 12, 2010, and repeat the INR test on July 12, 2010.

3. A daily Coumadin audit has been implemented. (Monday through Friday). The chart with the physician’s order, the Medication Administration Record, the Coumadin log, and the computerized physician’s orders are checked by four nurses daily to ensure accuracy.

4. The Assistant Director of Nursing will report daily audit results to the Performance Improvement Committee (Executive Director, Director of Nursing, Medical Director, Rehab Manager, Director of Social Services, Activity Director, Dietary Manager, Medical Records, and Pharmacy Consultant) monthly for 12 months.

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Medical record review of the laboratory test results failed to reveal results for the physician ordered INR for July 12, 2010. Medical record review of the laboratory test results revealed results for an INR drawn on July 15, 2010, of 5.3 (above the 2.0-3.0 normal value) with physician's order to hold the Coumadin until July 18, 2010, and to repeat the INR test on July 19, 2010.

Interview on July 28, 2010, at 3:50 p.m., near the admissions office with Registered Nurse (acting assistant director of nursing) #2 revealed the INR for July 12, 2010, was not obtained as the physician ordered until July 15, 2010, (three days late).