<table>
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<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(DS) COMPLETION DATE</th>
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<tr>
<td>F241</td>
<td>D</td>
<td>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</td>
<td></td>
<td>Allegation of Substantial Compliance</td>
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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 policy review, observation and interview, it was determined the facility failed to ensure privacy was provided during a wheelchair to bed transfer for 1 of 31 (Resident #103) sampled residents included in the stage 2 review.

- The findings included:

  - Review of the facility's "Rights of Tennessee Nursing Facility Residents" policy documented, "...Confidentiality and Privacy... 1)... the facility will assure privacy in your... personal care..."

  - Observations in Resident #103's room on 3/31/14 at 9:45 AM, revealed Resident #103's privacy curtain did not go all the way around her bed for complete privacy.

  - During an interview in Resident #103's room on 3/31/14 at 10:10 AM, Resident #103 was asked if staff ensure privacy during care. Resident #103 stated, "My roommates family, a man, came in to visit her [roommate] and he watched me when they were using the lift to put me back to bed."

  - During an interview in the staff development office on 4/1/14 at 4:40 PM, the Housekeeping Director was asked if the curtains are hung based on the size that fits the area of room to ensure

---

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above areducible 90 days following the date of survey unless a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.

[Signature]

Administrator

4-23-14
F 241 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 policy review, observation and interview, it was determined the facility failed to ensure privacy was provided during a wheelchair to bed transfer for 1 of 31 (Resident #103) sampled residents included in the stage 2 review.

The findings included:

Review of the facility's "Rights of Tennessee Nursing Facility Residents" policy documented, "...Confidentiality and Privacy... 1)... the facility will assure privacy in your... personal care..."

Observations in Resident #103's room on 3/31/14 at 9:45 AM, revealed Resident #103's privacy curtain did not go all the way around her bed for complete privacy.

During an interview in Resident #103's room on 3/31/14 at 10:10 AM, Resident #103 was asked if staff ensured privacy during care. Resident #103 stated, "My roommates family, a man, came in to visit her [roommate] and he watched me when they were using the lift to put me back to bed."

During an interview in the staff development office on 4/1/14 at 4:40 PM, the Housekeeping Director was asked if the curtains are hung based on the size that fits the area of room to ensure...
<table>
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<th>Event</th>
<th>Description</th>
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| F 241 | Continued From page 1
complete privacy. The Housekeeping Director stated, "We don't, we do have different sizes, and we put up what is clean." The Housekeeping Director was asked if she was aware that some of the curtains did not provide complete privacy. The Housekeeping Director stated, "No, I was not aware that some of the curtains did not provide complete privacy.

During an Interview in the staff development office on 4/1/14 at 8:30 PM, the Director of Nursing (DON) was asked what her expectation was regarding the privacy of a resident's personal care delivery, if the curtains don't provide complete privacy. The DON stated, "That is not acceptable. I would assign myself or someone else and audit every room to make sure they [the curtains] completely close and also in-service the staff if they find one [a curtain that doesn't close completely] that they report it immediately to change them out..." |
| F 278 | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

F 278 483.20 (g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The facility will ensure the assessment will accurately reflect the resident’s status.

On or before 4/30/14, Medical Record Nurse and MDS Nurse will be in-serviced. The in-service will be conducted by the Director of Nursing or Designee and will include:

- Review of the regulation
- Review of the statement of deficiency
F 278 Continued From page 2

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to ensure the Minimum Data Set (MDS) assessment was updated and accurate related to a urinary tract infection for 1 of 19 (Resident #71) sampled residents of 31 residents included in the stage 2 review.

The findings included:

Medical record review for Resident #71 documented an admission date of 12/3/13 with diagnoses of Dementia, Hypertension, Edema, Osteoporosis, Dysphagia, Diabetes Mellitus Type 2, Hyperlipidemia, Anxiety, Hypocalcemia, Esophageal Reflux, Generalized Pain, Insomnia and Hypertonicity of Bladder. Review of the MDS dated 3/12/14 documented Resident #71 had not been diagnosed with a Urinary Tract Infection (UTI) in the past 30 days.

Review of nurses notes documented the
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<th>F 278</th>
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<td></td>
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<td>following:</td>
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<td></td>
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<td>a. 3/10/14 - &quot;...Ua [urinalysis] c&amp;s [culture and sensitivity] rec'd [received], + [positive] for Escherichia coli... new order per... fnp [family nurse practitioner] for cipro 500 [milligrams] po [by mouth] BID [two times a day] X [times] 7 days...&quot;</td>
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<td>b. 3/12/14 - &quot;...Res [resident] continues with cipro [Ciprofloxacin] r/t [related to] uti...&quot;</td>
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<td>Review of the care plan dated 3/27/14 documented, &quot;...Resident ha [has] UTI... Date Initiated: 3/10/2014...&quot;</td>
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<td>During an interview in the staff development office on 4/2/14 at 11:30 AM, the MDS Coordinator was asked why she coded Resident #71 had a decline in activity of daily living on the most recent MDS dated 3/12/14. The MDS Coordinator stated, &quot;I think she had a UTI that made it go down just a little bit. I didn't do a significant change because it was a UTI. I figured it would get better after the UTI.&quot;</td>
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<td>During an interview in the business office on 4/2/14 at 4:30 PM, the Director of Nursing (DON) was asked if a resident has a UTI, should that information be included in the assessment and in the care plan. The DON stated, &quot;Yes, and then removed or updated when it resolves.&quot;</td>
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<td>During an interview in the staff development office on 4/2/14 at 5:10 PM, the MDS Coordinator was asked if the MDS dated 3/12/14 should have included Resident #71's UTI. The MDS Coordinator stated, &quot;Yes, I must have overlooked it. I'll have to make a correction.&quot;</td>
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<td>F 280</td>
<td>483.20(d)(3), 483.10(k)(2) RIGHT TO</td>
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<td>F 280</td>
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### Summary Statement of Deficiencies

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<th>Prefix Tag</th>
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<tr>
<td>F 280</td>
<td>PARTICIPATE PLANNING CARE-REVISE CP</td>
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The resident has the right, unless adjudged incompetent or otherwise found to be 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, it was determined the facility failed to revise the care plan to reflect the current status related to pressure ulcers for 1 of 19 (Resident #80) sampled residents of the 31 residents included in the stage 2 review.

The findings included:

Medical record review for Resident #80 documented an admission date 10/23/12 with a readmission date of 3/12/13 with diagnoses of Alzheimer's Disease, Dementia with Behavioral

### Plan of Correction

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<th>Description</th>
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<tr>
<td>F 280</td>
<td>F 280 483.20 (d) (3), 483.10(h)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</td>
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</tbody>
</table>

The facility will ensure that the resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

On or before 4/30/14 Licensed Nurses will be inserviced. The in-service will be conducted by the Director of Nursing or Designee and will include:

- Review of the regulation
- Review of the statement of deficiency
- Review of the plan of correction
- All Licensed Nurses will be trained on how to input changes on careplan. Nurses will enter changes on all new or charted Wounds, URI's and UTI's.
- MDS nurse will check orders within 72 hours and ensure that careplan was updated appropriately.

Resident #80 has discharged from the facility.
F 280 Continued From page 5
Disturbances, Chronic Airway Obstruction, Coronary Atherosclerosis Vessel Native/Graft, Chronic Ischemic Heart Disease, Hypertension, Adult Failure to Thrive, Hypothyroidism, Anxiety, Hyperlipidemia, Impulse Control Disorder, Intermittent Explosive Disorder, Depression, Insomnia, Constipation, Hallucinations, Dysphagia, Neurogenic Bladder and Personal History of Fall.

Review of the care plan dated 2/12/14 documented, "...potential risk for skin impairment sec [secondary] to decreased mobility and urinary incontinence... Change briefs on rounds and pm [as needed]... skin checked at care times and pm, pressure reduction cushion to WC [wheelchair], pressure reduction mattress to bed, turn and reposition q [every] 2 hrs [hours] as tolerated, report refusal to CN [Charge Nurse]... Resident has a potential for ulcers sec to decreased mobility, deconditioning, incontinence... assist/encourage to turn and reposition on rounds and pm... Off load heels/feet with pillows or wedges as tolerated... report noncompliance to CN, skin prep to bilat [bilateral] heels q shift..."

Review of the "Weekly Skin Audit" dated 3/7/14 documented, "...a pressure ulcer to right heel length 1.0 width 1.5 and unstageable..."

The care plan was not revised to reflect the pressure ulcer identified on 3/7/14.

483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

F 281 483.20 (k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS
This REQUIREMENT is not met as evidenced by:
Based on policy review, observation and interview, it was determined the facility failed to ensure 1 of 4 (Nurse #2) medication nurses disposed of medications within an acceptable standard of practice.

The findings included:
Review of the facility's "HEALTH CARE PHARMACY SERVICES..." policy documented, "...DESTRUCTION OF MEDICATION ON FACULTY PREMISES... POLICY... TO INSURE THE NON - VIABILITY OF CONTROLLED AND OR NON - CONTROLLED SUBSTANCE... PROCEDURE... MEDICATION IS TO BE PLACED INTO SHARP'S CONTAINER... USING COFFEE GROUND OR KITTY LITTER AND OR HOT COFFEE TO BE POURED [poured] OVER MEDICATIONS TO INSURE [ensure] THE NON - VIABILITY OF THE MEDICATION... Revised Policy for Hillcrest R/T [related to] CHANGE IN PROCEDURE 2-1-2014..."

Observations in the employee restroom on 4/1/14 at 10:35 AM, revealed Nurse #2 disposed of the following medications by flushing them in the commode:
a. Aspirin 81 mg (milligrams) - 1 tablet.
b. Geri-Kot Senna 8.5 mg - 2 tablets.
c. Lisinopril 10 mg - 1 tablet.
d. Seroquel 25 mg - 1 tablet.
e. Coreg 3.125 mg - 1 tablet.
f. Lasix 40mg - 1 tablet.
g. Plavix 75 mg - 1 tablet.
h. Levetiracetam 500 mg - 1 tablet.

The facility will ensure the services provided or arranged by the facility must meet professional standards of quality.

On or before 4/30/14, licensed nurses will be inserviced. The in-service will be conducted by the Director of Nursing or Designee and will include:
- Review of the regulation
- Review of the statement of deficiency
- Review of the plan of correction
- Pharmacy has provided the facility with a policy on the proper way to dispose of medication during a med pass.
- All licensed nurses will be inserviced on proper way to dispose of medications based on pharmacy policy.

Nurses will be audited by DON or Designee during med pass to ensure proper disposal of medications.

Beginning 5/1/14 The Administrator or designee will monitor for continued compliance thorough Quality Improvement audits. (See Attachment D) The audits will be completed weekly for one month and monthly for one quarter. The Administrator or designee will report to the QA/QI
F 281
Continued From page 7
The Minimum Data Set (MDS) Coordinator was also present as a witness.

During a telephone interview in the staff development office on 4/2/14 at 3:25 PM, the Clinical Coordinator / Chief Operating Officer of the Pharmacy was asked if it was an acceptable practice to flush drugs down the toilet when being wasted. The Clinical Coordinator / Chief Operating Officer stated, "Flushing is no longer an acceptable practice."

483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE

Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to prevent the decline in activities of daily living (ADL) related to the development of a urinary tract infection (UTI) for 1 of 2 (Resident #71) sampled residents of 31 residents included in the stage 2 review.

The findings included:
Medical record review for Resident #71 documented an admission date of 12/3/13 with committee who will determine the frequency of further monitoring.

Completion date: 5/1/14

F 310

F 310 483.25 (a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE

Based on the comprehensive assessment of a resident the facility will ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable.

On or before 4/30/14, MDS nurse and Medical Records Nurse will be inserviced. The in-service will be conducted by the Director of Nursing or Designee and will include:

- Review of the regulation
- Review of the statement of deficiency
- Review of the plan of correction
- During an MDS assessment if an acute illness is noted, the MDS nurse will reassess and
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:**

**445316**

**NAME OF PROVIDER OR SUPPLIER:**

**HILLCREST HEALTHCARE CENTER**

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

**111 E PEMBERTON STREET**

**ASHLAND CITY, TN 37015**

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<tr>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X9) COMPLETION DATE</th>
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<td>F 310</td>
<td>Continued From page 8 diagnoses of Dementia, Hypertension, Osteoporosis, Dysphagia, Hyperlipidemia, Anxiety, Diabetes Mellitus Type 2, Edema, Hypopotassemia, Esophageal Reflux, Insomnia, Generalized Pain, and Hypertonicity of Bladder. Review of the minimum data set (MDS) dated 1/30/14, documented Resident #71 required limited assistance with one person physical assistance with the ADLs of bed mobility, transfers, and toilet use. The MDS documented that Resident #71 required physical help in part of bathing activity with one person physical assist. The MDS also documented that Resident #71 was independent but required one person physical assistance for dressing, and required supervision with setup help only for personal hygiene. The MDS dated 3/12/14, documented Resident #71 required extensive assistance with one person physical assist for ADL's including bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS also documented that Resident #71 was totally dependent on staff for bathing, requiring two+ persons physical assistance. During an interview in the staff development office on 4/2/14 at 11:30 AM, the MDS Coordinator was asked why she coded Resident #71 had a decline in ADL's on the most recent MDS dated 3/12/14. The MDS Coordinator stated, &quot;I think she had a UTI that made it go down just a little bit. I didn't do a significant change because it was a UTI. I figured it would get better after the UTI.&quot; During an interview in the medical records office</td>
<td>F 310</td>
<td>evaluate the resident for significant change. If the spell of illness is not expected to resolve and that resident will not return to functional level preceding illness, then a significant change will be completed by MDS nurse. Resident #71's UTI illness has resolved and resident has returned to functional level. Telephone orders will be reviewed by Medical Records nurse during weekday clinical meeting for any new orders of acute illness that is not expected to resolve or return the resident to prior functioning preceding the illness. Beginning 5/1/14 The Administrator or designee will monitor for continued compliance through Quality Improvement audits. (See Attachment B) The audits will be completed weekly for one month and monthly for one quarter. The Administrator or designee will report to the QA/QI committee who will determine the frequency of further monitoring. Completion date: 5/1/14</td>
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<tr>
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<td>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</td>
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<td>F 310</td>
<td>Continued From page 9 on 4/2/14 at 12:15 PM, the nurse practitioner (NP) was asked whether Resident #71's decline in ADLs was a result of the UTI. The NP stated, &quot;I only manage her acute issues.&quot; The NP was asked whether she felt a UTI could possibly cause a decline in ADLs. The NP stated, &quot;Yes.&quot;</td>
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<td>F 314</td>
<td>SS=E</td>
<td>TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</td>
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<td>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to prevent infection and prevent new sores from developing.</td>
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This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to have a system in place to teach staff nurses consistent wound care to assure accurate assessments, interventions and monitoring of pressure ulcers for 2 of 4 (Residents #80 and 88) sampled residents included in the stage 2 review with pressure ulcers.

The findings included:

1. Medical record review for Resident #80 documented an admission date 10/23/12 with a readmission date 3/12/13 with diagnoses Alzheimer's Disease, Dementia with Behavioral Disturbances, Chronic Airway Obstruction,
F 314 Continued From page 10
Coronary Atherosclerosis Vessel Native/Graft,
Chronic Ischemic Heart Disease, Hypertension,
Adult Failure to Thrive, Hypothyroidism,
Hyperlipidemia, Impulse Control Disorder,
Intermittent Explosive Disorder, Depression,
Anxiety, Hallucinations, Insomnia, Dysphagia,
Constipation, Neurogenic Bladder and Personal
History of Fall.

Review of the care plan dated 2/12/14
documented, "...potential risk for skin impairment
sec [secondary] to decreased mobility and urinary
incontinence... Change briefs on rounds and pm
[as needed]... skin checked at care times and
pm, pressure reduction cushion to WC
[wheelchair], pressure reduction mattress to bed,
turn and reposition q [every] 2 hrs [hours] as
tolerated, report refusal to CN [Charge Nurse]...
Resident has a potential for ulcers sec to
decreased mobility, deconditioning,
incontinence... assist/encourage to turn and
reposition on rounds and pm... Off load heels/feet
with pillows or wedges as tolerated...report
noncompliance to CN, skin prep to bilat [bilateral]
heels q shift...
"

Review of the "Braden Scale for Predicting
Pressure Sore Risk" dated 2/27/14 documented,
"...very high risk 8.0..."

Review of the "Weekly Skin Audit" dated 3/7/14
documented, "...a pressure ulcer to right heel
length 1.0 width 1.5 and unstageable...
"

Review of a Hospice note dated 3/7/14
documented, "...Stage 1 wound was noted on R
[right] heel..." Then in 3 days was unstageable.

Review of the "Weekly Skin Audit" dated 4/1/14
routine bases which
includes on hire, quarterly
and as needed. Hospices
nurses entering facility
will be observed by
facility nurses and notes
concerning wound
measurements will be
audited for accuracy. If a
problem is found, hospice
company will be notified
to provide wound
measurement training and
note will be provide to
accurately reflect wound
measurements by facility
nurse.

- Weekly skin audits will
be reviewed and wound
will be observed to ensure
accuracy in
documentation.

Resident #80 discharged from facility and
Resident #86's wound has been reevaluated
and accurately staged.

All pressure ulcers will be reviewed weekly
during RAR by IDT team to ensure
appopriate staging and treatment.

Beginning 5/1/14 The Administrator or
designee will monitor for continued
compliance thorough Quality Improvement
audits. (See Attachment E) The audits will
be completed weekly for one month and
monthly for one quarter. The Administrator
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<th>COMPLETION DATE</th>
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| F 314        |Continued From page 11 documented, "...a pressure ulcer to right heel length 1.0; width 1.0; and depth a scab and unstageable..." During a telephone interview in the staff development office on 4/2/14 at 3:50 PM, the Hospice Nurse stated, "They [facility staff] told me about a Stage 1 wound to the right heel in January, 2014 when I took [named resident] on as a patient. When I looked at the wound I saw it was unstageable. Then they started calling it unstageable... I know it was unstageable, I don't know why I charted Stage I... No, [named resident] has not had much improvement [in the wound]... I see that resident twice a week... The facility does the orders for the wounds but we [hospice] provide the supplies for dressing changes and the facility nurses do the dressing changes... I go in and do measurements each week for hospice and do assessing for us [hospice]."
| F 314        |or designee will report to the QA/QI committee who will determine the frequency of further monitoring. Completion date: 5/1/14 |

2. Medical record review for Resident #86 documented an admission date of 7/29/13 with diagnoses of Rheumatoid Arthritis, Congestive Heart Failure, Atrial Fibrillation, Hypertension, Chronic Airway Obstruction, Gout, Anemia, Chronic Pain Syndrome, Peripheral Vascular Disease, Pressure Ulcer Stage 2, Constipation, Edema, Muscle Spasm, Personal History of Fall and Diarrhea.

Review of the admission minimum data set (MDS) dated 8/11/13 documented a Brief Interview of Mental Status (BIMS) score of 15. A Braden scale completed on 8/15/13 had no documentation for pressure ulcers being present but documented the resident was at risk of developing pressure ulcers. Documentation for
pressure reducing device for chair, pressure reducing device for bed, turning / repositioning program, nutrition and hydration intervention to manage skin problems, applications of ointments/medications other than to feet, application of nonsurgical dressings other than to feet, and application of dressings to feet.

Review of a nurse's note dated 10/26/13 documented, "...New order per [name MD] cleanse stg [stage] II pressure ulcer between R great toe at [and] 2nd toe with NS [Normal Saline], pat dry, apply calcium alginate et cover with a bandaid q day et [and] pm. Monitor for s/s [signs and symptoms] of infection q shift..."

Review of the weekly skin audits documented the following:

a. 10/26/13 - "...R grt [great] toe, pressure, 1.0 length, 1.0 width, stage 2... New stg 2 to Rt [right] grt toe bx [treatment] in progress..."

b. 10/30/13 - "...R grt toe, pressure, 0.7 length, 0.7 width, depth UTD [unable to determine]..."

c. 1/1/14 - "...R grt toe, pressure, 1.0 length, 1.0 width, depth UTD..."

d. 1/9/14 - "...R grt toe, pressure, 9.5 length, 4.0 width, depth UTD depth, Stage IV..."

e. 2/28/14 - "R grt toe, pressure, 0.8 length, 0.8 width, UTD depth, stage unstageable..."

f. 3/12/14 - "R grt toe, pressure, 0.6 length, 0.3 width, UTD depth, stage IV..."

g. 3/20/14 - "...R grt toe, pressure, 0.8 length, 0.4 width, UTD depth, stage IV..."

h. 3/28/14 - "...R grt toe, pressure, 0.6 length, 0.4 width, UTD depth..."

Review of the "Braden Scale for Predicting Pressure Sore Risk" documented the following:

a. 7/29/13 - a score of 15 which indicated low
Continued From page 13
risk.
b. 11/11/13 - a score of 12 which indicated high risk.
c. 2/11/14 - a score of 11 which indicated high risk.

Review of the care plan revised on 1/1/14 documented, "...Resident has a potential for ulcers sec to decreased mobility... assist / encourage to turn and reposition on rounds and pm, if open areas, redness, other impairments occur alert MD [medical doctor], off load heels/feet with pillows or wedges as tolerates... Resident at risk for infection or further impairment sec to a stg [stage] 2 to Rt [right] great toe...11/14/13 now stg 4..."

Review of the MDS dated 2/11/14 documented a BIMS score of 13 and skin conditions documented Resident #86 had 1 pressure ulcer stage 1 or greater, was at risk of pressure ulcer and had one or more unhealed pressure ulcers at stage 1 one or higher. Resident had 1 unstageable pressure ulcer due to coverage of wound bed by slough or eschar and had 1 of these unstageable pressure ulcers that were present upon admission/entry or reentry.

3. During an interview in the staff development office on 4/2/14 at 10:35 AM, the Director of Nursing (DON), was asked about the pressure ulcer training procedure. The DON stated, "I've already told the ED [Executive Director] every new nurse will be 30 days with one nurse [training] for those 30 days. Then we evaluate if they are comfortable doing things... Stage 4 [ulcer] should get a depth on it..." The DON was asked how an ulcer was stage 4 then on 2/20/14 it was unstageable. The DON stated, "How could
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/LIAISON IDENTIFICATION NUMBER
445316

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

(X3) DATE SURVEY COMPLETED
04/01/2014

NAME OF PROVIDER OR SUPPLIER
HILLCREST HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
111 E PEMBERTON STREET
ASHLAND CITY, TN 37015

(F4) ID PREFIX TAG

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

F 314 Continued From page 14
it be stage IV then can’tstage it [unstageable]... Every nurse in the building should be able to assess and stage a wound... Once a wound is a stage 4 it can only be a 4 but a healed or unhealed stage 4..."

During an interview in the staff development office on 4/2/14 at 2:57 PM, the Staff Development Coordinator was asked to see wound care in-services with a roster and the curriculum that was taught to the nurses. The Staff Development Coordinator stated, "I am unable to find any wound care inservices."

During an interview in the staff development office on 4/2/14 at 5:25 PM, the Staff Development Coordinator was asked again about any wound care in-services provided to the staff. The Staff Development Coordinator stated, "The staff needs more education on wound care. We are looking to hire 2 nurses that are wound care certified."

F 315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

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

F 315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

Based on the resident’s comprehensive assessment, the facility will ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident’s clinical conditions 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.
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<tr>
<th>(X4) ID PREFIX TAG</th>
<th>(X4) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEG IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>(X5) 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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</thead>
</table>
| F 315            | Continued From page 15 by: Based on medical record review and interview, it was determined the facility failed to provide timely treatment for a urinary tract infection (UTI) for 1 of 5 (Resident #71) sampled residents identified with a UTI of the 31 residents included in the stage 2 review. The findings included: Medical record review for Resident #71 documented an admission date of 12/3/2013 with diagnoses of Dementia, Hypertension, Anxiety, Osteoporosis, Dysphagia, Hyperlipidemia, Edema, Diabetes Mellitus Type 2, Esophageal Reflux, Generalized Pain, Insomnia, Hypertonicity of Bladder and Hypopotassemia. Review of the minimum data set (MDS) dated 1/30/14, documented Resident #71 required limited assistance with one person physical assistance with the ADLs of bed mobility, transfers, and toilet use. The MDS documented that Resident #71 required physical help in part of bathing activity with one person physical assist. The MDS also documented that Resident #71 was independent but required one person physical assistance for dressing, and required supervision with setup help only for personal hygiene. The MDS dated 3/12/14, documented Resident #71 required extensive assistance with one person physical assist for ADL's including bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS also documented that Resident #71 was totally dependent on staff for bathing, requiring two persons physical assistance. | On or before 4/30/14, licensed nurses will be inserviced. The in-service will be conducted by the Director of Nursing or Designee and will include:  
- Review of the regulation  
- Review of the statement of deficiency  
- Review of the plan of correction  
- Charge nurses will ensure that all labs are obtained and sent to lab.  
- When abnormal lab results are received the Charge nurse will notify MD and/or NP immediately  
- DON or Designee will review all labs to ensure that charge nurses are following facility policy concerning notification of MD  
Resident #71's illness has resolved.  
SDC or Designee reviews labs and reports all abnormal labs level during weekday clinical meeting.  
Beginning 5/1/14 The Administrator or designee will monitor for continued compliance thorough Quality Improvement audits. (See Attachment F) The audits will be |
F 315

Continued From page 16

Review of a nurses note dated 2/17/14 documented, "...Resident [71] was found in floor between bed and wheelchair with alarm sounding, resident was yelling... assessed for injury... assisted back to bed... [Resident #71's physician] notified, N/Q [new order] rec [received] for psych [psychiatric] consult..."

Review of a behavioral medicine progress note dated 2/17/14 for Resident #71 documented, "...Chief Complaint: Confusion and anxiety... Order Labs: UA [urinalysis] C&S [culture and sensitivity] for altered mental status..."

Review of a nurses note dated 2/19/14 for Resident #71 documented, "...new order per [Resident #71's physician] U/A with c&s for altered mental status..."

Review of a urinalysis (UA) dated 2/19/14 for Resident #71 documented, "...LEUKOCYTES 1+ [plus], Reference Range... NEGATIVE... NITRITE POSITIVE... Reference Range... NEGATIVE... WBC [white blood cells] 4-10 [to] 8... BACTERIA 3+... CULTURE, URINE PENDING... [Nurse Practitioner's (NP) initials] 02/21/14 Await culture..."

Review of the urine culture results for Resident #71 documented, "...DATE DRAWN 2/19/14... DATE REPORTED 02/22/2014... CULTURE SOURCE URINE... ORGANISM ESCHERICHIA COLI!... [NP's initials] 03/05/14 Repeat UA C&S..."

Review of a UA for Resident #71 documented, "...DATE DRAWN 3/14... DATE REPORTED 03/08/2014... URINALYSIS... LEUKOCYTES TRACE... REFERENCE RANGE... NEGATIVE..."
F 315 Continued From page 17

NITRITE POSITIVE... REFERENCE RANGE...
NEGATIVE... BACTERIA 3+... CULTURE
SOURCE URINE... ORGANISM ESCHERICHIA
COLI... [NP's initials] 03/10/14 Cipro 500mg
[milligrams] PO [by mouth] BID [twice per day] X
[times] 7 days..."

Review of a telephone prescriber's order dated
3/10/14 documented, "...Cipro 500mg po BID X 7
days... INDICATION-DX [diagnosis] Ecoli
[Escherichia Coli] in urine..."

During an interview at the nurses' station on
4/1/14 at 4:30 PM, Nurse #1 was asked if
Resident #71 was started on an antibiotic after
the 2/19/14 UA and urine culture results were
received. Nurse #1 looked at medical record and
stated, "If there had been an antibiotic we would
have had to chart on it for X [days administered]
amount of days. [I am] not seeing that..."

During an interview in the staff Development
office on 4/1/14 at 6:00 PM, the Director of
Nursing was asked if Resident #71 was started
on antibiotics when results from 2/19/14 UA and
urine culture were known. The DON stated, "I
cannot find where any antibiotics were ordered
until the NP was notified in March."

During an interview in the hall beside the staff
development office on 4/2/14 at 10:10 AM, the
NP was asked when she was notified of Resident
#71's abnormal UAC&S. The NP stated, "Did not
see it until 3/5/14."

During an interview in the staff development
office on 4/2/14 at 3:00 PM, Nurse #3 was asked
for the policy regarding the facility's timeframe for
reporting abnormal lab results to the physician.
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 315</td>
<td>Continued From page 18 Nurse #3 stated, &quot;There's no written policy.&quot;</td>
<td>F 315</td>
<td>F 325 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</td>
<td></td>
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<tr>
<td>F 325</td>
<td>Based on resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</td>
<td></td>
<td>Based on resident's comprehensive assessment, the facility will ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident’s clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</td>
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<tr>
<td>SS=D</td>
<td>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the facility failed to implement interventions for a significant weight loss for 1 of 3 (Resident #69) sampled residents of 6 residents that were reviewed for nutrition. The findings included: Review of the facility's &quot;Weight/Weight Loss&quot; policy documented: &quot;...1. Resident with significant weight loss will be added to weekly weights until stabilized... Notify the physician and family... Document on resident's significant weight loss and weight loss interventions...&quot; Medical record review for Resident #69 documented an admission date of 9/17/13 with diagnoses of Pre Senile Dementia with</td>
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<td>SUMMARY STATEMENT OF DEFICIENCIES</td>
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<td>F 325</td>
<td>Continued From page 19</td>
<td>Delusional Features, Osteoarthritis, Kyphosis, Osteoporosis, Cerebrovascular Disease, Atrial Fibrillation, Hypertension, Gastro Esophageal Reflux Disease, Glaucoma, Pain, Urinary Incontinence, and Constipation. Resident #69 was hospitalized in February 2014 for nose surgery. Review of the admission minimum data set (MDS) dated 9/30/13 documented a Brief Interview for Mental Status (BIMS) score of 11 and no weight loss. The quarterly MDS dated 12/31/13 documented a BIMS score of 14 and no weight loss. Review of a care plan dated 1/1/14 documented, &quot;...nutritional deficits sec [secondary] to diuretic usage, therapeutic diet, constipation...&quot; Review of the weight record documented a weight on 2/3/14 of 107 pounds and a weight on 3/12/14 of 99.6 pounds which was a 6.9 percent (%) loss in 1 month. Observations in Resident #69's room on 4/2/14 at 8:50 AM, the Restorative Aide (RA) weighed Resident #69 using a chair scale. The RA made sure the scale was at 0 and stated, &quot;The company calibrates it regularly, and it [the chair scale] was calibrated a couple of weeks ago...&quot; Resident #69 was placed in the chair and her feet were placed on the footrest. Resident #69's weight read 105.5 pounds. During an interview in the dining room on 4/1/14 at 7:00 PM, the Dietary Manager (DM) was asked about Resident #69's weight loss. The DM stated, &quot;I did calculate it [the weight loss] but did not transfer the information to my summary so the loss, adequate interventions will be discussed with RD and reviewed in weekly RAR meeting. Resident #69 was reweighed and placed on weekly weights for monitoring. Residents with significant weight loss will be reviewed by CDM and RD. MD and Responsible Party will be notified. Discussions concerning weight loss of any resident will be held in weekly RAR meeting. Beginning 5/1/14 The Administrator or designee will monitor for continued compliance through Quality Improvement audits. (See Attachment G) The audits will be completed weekly for one month and monthly for one quarter. The Administrator or designee will report to the QA/QI committee who will determine the frequency of further monitoring. Completion date: 5/1/14</td>
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| F 325 | Continued From page 20 dietician isn't aware."
During an interview outside the employee break room on 4/2/14 at 9:30 AM, the Administrator was made aware of the weight loss. The Administrator was asked what her expectation was when a weight loss is identified. The Administrator stated, "My expectation is that the DM reports the weight loss to the RD [Registered Dietitian]."

F 329

483.25 (I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

F 329 483.25 (I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

Each resident's drug regimen will be free from unnecessary drugs. On or before 4/30/14, DON/NP/MD will be inserviced. The in-service will be conducted by the Administrator or Designee and will include:

- Review of the regulation
- Review of the statement of deficiency
- Review of the plan of correction
- All pharmacy recommendations will be reviewed by DON or Designee and then forwarded to MD/NP who will review and write orders as deemed necessary.

Resident #38 medication has been changed to BID the NP is monitoring resident and plans to follow Pharmacist recommendation if appropriate based on resident behavior.

All pharmacy recommendations are sent to DON or designee and are forwarded on
<table>
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<th>F 329</th>
<th>Continued From page 21</th>
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<tr>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on medical record review and interview, it was determined the facility failed to follow a physician's order for a gradual dose reduction for an anti-anxiety medication for 3 of 5 (Resident #38) sampled residents reviewed for unnecessary medications of the 31 residents included in the stage 2 review.</td>
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<td>The findings included:</td>
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<td>Medical record review for Resident #38 documented an admission date of 2/13/17 with a re-admission date of 7/1/09 with diagnoses of Diabetes, Dementia, Anxiety, Depression, Bone Disease, Reactive Confusion, Peripheral Vascular Disease, Constipation, Cellulitis to Left Lower Extremity, Joint Prosthesis, Alzheimer's Disease and Osteopenia.</td>
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<td>Review of the &quot;Pharmacy Recommendation Report&quot; dated 1/3/14 documented, &quot;Recommendation to decrease Klonopin to 0.5mg [milligrams] po [by mouth] q [every] HS [hour of sleep] [a decrease from 0.5mg po BID [two times a day]. The physician agreed and signed the recommendation on 1/9/14.</td>
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<td>Review of the physician's orders for Resident #38 documented the following:</td>
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<td>a. 1/8/14 - &quot;...clonazepam 0.5MG TABLET (...KOLONP[N] 1 TABLET BY MOUTH TWICE DAILY...&quot;</td>
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<td>b. 2/5/14 - &quot;...clonazepam 0.5MG TABLET (...KOLONP[N] 1 TABLET BY MOUTH AT BEDTIME [a line drawn was through &quot;at bedtime&quot; and &quot;BID&quot; was written above it]...&quot;</td>
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<td>c. 2/8/14 - &quot;Klonopin 0.5mg PO TID [three times a</td>
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<p>| F 329  | MD/NP. Pharmacy Consultant comes monthly and reviews prior month recommendations for follow up. |
|        | Beginning 5/1/14 The Administrator or designee will monitor for continued compliance thorough Quality Improvement audits. (See Attachment II) The audits will be completed weekly for one month and monthly for one quarter. The Administrator or designee will report to the QA/QI committee who will determine the frequency of further monitoring. Completion date: 5/1/14 |</p>
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<th>ID</th>
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<th>TAG</th>
<th>SF 329: Continued From page 22</th>
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</table>
| F 329 | Continued From page 22 | | day] for seizures. D/C [discontinue] Klonopin 0.5mg PO BID."
| d. 2/28/14 documented, "...KLONOPIN 0.5MG TABLET CLONAZEPAM 0.5 MG TABLET TAKE 1 [circled] BY MOUTH 2 TIMES DAILY..."
| | | | Review of Resident #38's Medication Administration Records (MAR) revealed the following:
| a. January, 2014 - received clonazepam (Klonopin) 0.5 mg two times per day from January 1st through January 31, 2014.
| b. February, 2014 - received clonazepam 0.5 mg two times per day from February 1st through February 7th, 2014 and clonazepam 0.5 mg three times per day from February 8th through February 18th, 2014. Resident #38 received clonazepam 0.5 mg one time on February 19th and 20th, 2014 and clonazepam 0.5 mg two times per day from February 21st through February 28th, 2014.
| c. March, 2014 - received Klonopin 0.5 mg two times per day from March 1st through March 31st, 2014.
| | | | Review of a care plan dated 11/10/10 and revised 4/1/14 documented, "...Focus... potential for adverse reactions rt [related to] psych [psychiatric] med [medication] use... interventions... Pharmacy review monthly..."
| | | | During an interview in the staff development office on 4/1/14 at 6:10 PM, the Director of Nursing (DON) was asked about the gradual drug reduction (GDR) recommendation from the pharmacist dated January, 2014. The DON stated, "I am reviewing the orders, and the med [medication] reconciliation for Feb. [February] changing it back to BID. I cannot find any
<table>
<thead>
<tr>
<th>Statement of Deficiencies and Plan of Correction</th>
<th>F 329</th>
<th>F 332 483.25 (m)(1) Free of Medication Error Rates of 5% or More</th>
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<tbody>
<tr>
<td>(x1) Provider/Supplier/Location Identification Number: 445316</td>
<td>Continued From page 23</td>
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<tr>
<td>(x2) Multiple Construction</td>
<td>A. Building __________________</td>
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<td>B. Wing __________________</td>
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<tr>
<td>(x3) Date Survey Completed:</td>
<td>04/01/2014</td>
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<tr>
<td></td>
<td>Name of Provider or Supplier: Hillcrest Healthcare Center</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Street Address, City, State, Zip Code: 111 E Pemberton Street, Ashland City, TN 37015</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(x4) Id Prefix Tag</td>
<td>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</td>
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<td>The facility must ensure that it is free of medication error rates of five percent or greater.</td>
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<td>F 329</td>
<td>Continued From page 23</td>
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<td>documentation regarding the order for GDR, I do not see an order until 2/8/14 and that order says to increase it. The original order was written on 3/28/13 bid [twice a day] for anxiety. In February, 2014, someone caught something, because the order was written over the pharmacy printed one -bid for anxiety. I cannot find any order for the GDR. Pharmacy had to have gotten it because it printed on the next month's [February] MAR.&quot; The DON was asked what her expectation was regarding medication reconciliation. The DON stated, &quot;If they see something, the nurse should have called the pharmacy and questioned the order printed on the physician order sheet.</td>
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<td></td>
<td>During an interview in the staff development office on 4/1/14 at 6:15 PM, the Administrator was asked who reviews the medication recommendations from pharmacy. The Administrator stated, &quot;I get it and the DON and that's it.&quot;</td>
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<td>SS=E</td>
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<td>On or before 4/30/14, licensed nurses will be inserviced. The in-service will be conducted by the Director of Nursing or Designee and will include:</td>
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<td></td>
<td>• Review of the regulation</td>
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<td>• All licensed nurses will be inserviced on how to</td>
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F 332  Continued From page 24
opportunities for errors resulting in a medication error rate of 40%.

The findings included:

1. Review of the medication guide for the long term care nurse, sixth edition, documented, "Spacing... Technique for Proper Use of Metered Dose Inhalers... Repeat puffs as directed... Waiting one minute between puffs..."

Observation in Resident #72's room on 4/1/14 at 8:05 AM, Nurse #1 administered Advair 250/50 1 puff, then immediately administered 2 consecutive puffs of Combivent inhaler, with less than 1 minute between each inhalation of either medication. The Combivent inhaler was not shaken prior to use.

During an interview in the staff development office on 4/2/14 at 10:15 AM, the Director of Nursing (DON) was asked what administration order she expected concerning inhalers. The DON stated, "I'd have to check on that."

Nurse #1 administering the two inhaler medications without waiting at least 1 minute between each puff which resulted in a medication error.

2. Observations outside Resident #105's room on 4/1/14 at 9:50 AM, Nurse #2 prepared Resident #105's the following 9 oral medications: 1 tablet of Aspirin 81 milligrams (mg), 2 tablets of Geri-Kot Senna 8.6 mg, 1 tablet of Lisinopril 10 mg, 1 tablet of quetiapine 25 mg, 1 tablet of Coreg 1.25 mg, 1 tablet of Lasix 40 mg, 1 tablet of Plavix 75 mg and 1 tablet of Levetiracetam 500 mg. Nurse #2 poured the medications into the

properly administer and MDI inhalers.
• All licensed nurses will be inserviced on proper administration of all medications.

Med passes will be audited by Pharmacy or Designee randomly on an ongoing basis to ensure proper Medication administration.

Beginning 5/1/14 The Administrator or designee will monitor for continued compliance through Quality Improvement audits. (See Attachment I) The audits will be completed weekly for one month and monthly for one quarter. The Administrator or designee will report to the QA/QI committee who will determine the frequency of further monitoring. Completion date: 5/1/14
medication cups and then counted them before administering to the resident. There were 7 pills in the cup. Nurse #2 looked on top of the medication cart and on floor around the cart. Nurse #2 found 2 loose pills in a paper cup on top of the medication cart that was filled with pill packages ready for discard. Nurse #2 stated, "I am going to hold it until I talk to the pharmacy and verify before I give it, that would be the safest thing to do." Nurse #2 placed the medication cup containing the pills in the medication cart with a note, and stated, "Until I can justify, I'll keep a name with it. as soon as I find out I'll come down here and administer them."

At the nurses' station on 4/1/14 at 10:14 AM, Nurse #2 called the pharmacist and described the 2 pills that she had found in the paper cup and asked the pharmacist to verify the medications based on her description over the phone. Nurse #2 stated, "[Named pharmacist] identified the pills."

On 4/1/14 at 10:23 AM, Nurse #2 took the cup containing the medications to Resident #105's room and checked Resident #105's radial pulse. Nurse #2 attempted to check the resident's blood pressure, but was unable to do so due to problems with the inflation of the cuff. Nurse #2 placed the cup of pills on the resident's bedside table and went into the resident's bathroom to wash her hands. Nurse #2 came out of the resident's bathroom, picked up the cup of pills, and took them with her down the hall to retrieve another blood pressure cuff. Nurse #2 then returned to Resident #105's room and checked the blood pressure. Nurse #2 then stated to Resident #105, "Time for your medicine. Do you want to sit up." Nurse #2 assisted the resident to
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<tr>
<td>F 332</td>
<td>Continued From page 26 sit up in bed and proceeded to give him a cup of water and the cup of pills. The surveyor intervened and asked the nurse to stop the medication administration. This resulted in 9 medication errors.</td>
<td>F 332</td>
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<td>During an interview in Resident #105’s room on 4/1/14 at 10:25 AM, Nurse #2 was asked if she could identify every pill in the cup, and what was the facility's policy regarding medication identification. Nurse #2 stated, &quot;I don't know.&quot; Nurse #2 was asked what her supervisor said regarding administering these medications. Nurse #2 stated, &quot;I didn't ask. I will go and do that right now.&quot;</td>
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<td>During an interview in the medication room on 4/1/14 at 10:35 AM, the Director of Nursing (DON) was asked if it is acceptable to have pharmacy identify pills over the phone before administration to a resident. The DON stated, &quot;I don't know the specific policy. I am new to the facility, but should loss them and call pharmacy to bring more. They [pharmacy] are not far away. If carried the pills to the nurse's station, touched them at all it is not safe to administer them to the resident.&quot;</td>
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<td>F 428</td>
<td>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</td>
<td>F 428</td>
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<td>SS=D</td>
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</table>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(x1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 

443516

(x2) MULTIPLE CONSTRUCTION 

A. BUILDING ____________________ 

B. WING ____________________ 

(x3) DATE SURVEY COMPLETED 

04/01/2014

NAME OF PROVIDER OR SUPPLIER 

HILLCREST HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 

111 E PEMBERTON STREET 

ASHLAND CITY, TN 37015

(x4) ID 

PREFIX TAG 

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

ID 

PREFIX TAG 

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 

(x5) COMPLETION DATE 

F 428 Continued From page 27 

F 428 by the Administrator or Designee and will include:

- Review of the regulation 
- Review of the statement of deficiency 
- Review of the plan of correction 
- Pharmacist will continue to review residents monthly and recommendations will be reviewed by DON and forwarded to MD/ NP for review and act upon as deemed necessary.

Resident #38 medication has been changed to BID the NP is monitoring resident and plans to follow Pharmacist recommendation if appropriate based on resident behavior.

All pharmacy recommendations are sent to DON or designee and are forwarded on MD/NP. Pharmacy Consultant comes monthly and reviews prior month recommendations for follow up.

Beginning 5/1/14 The Administrator or designee will monitor for continued compliance through Quality Improvement audits. (See Attachment II) The audits will be completed weekly for one month and monthly for one quarter. The Administrator or designee will report to the QA/QI

This REQUIREMENT is not met as evidenced by:

Based on pharmacy review, medical record review and interview, it was determined the facility failed to address a drug order irreguality during a monthly medication reconciliation for an antianxiety medication for 1 of 5 (Resident #38) sampled residents of 5 residents reviewed for unnecessary medications of the 31 residents included in the stage 2 review.

The findings included:

Medical record review for Resident #38 documented an admission date of 2/13/17 with a re-admission date of 7/1/17 with diagnoses of Diabetes, Dementia, Anxiety, Depression, Bone Disease, Reactive Confusion, Peripheral Vascular Disease, Constipation, Cellulitis to Left Lower Extremity, Joint Prosthesis, Alzheimer's Disease and Osteopenia. Review of a care plan dated 11/10/17 and revised 4/14/14 documented, "...Focus... potential for adverse reactions /t [related to] psych [psychiatric] med [medication] use... Interventions... Pharmacy review monthly..." 

Review of the "Pharmacy Recommendation Report" dated 1/3/14 documented,

"...Recommendation to decrease Klonopin to 0.5mg [milligrams] po [by mouth] q [every] HS [hour of sleep] [a decrease from 0.5mg po BID [twice daily]. The physician agreed and signed the recommendation on 1/9/14."
F 428 Continued From page 28

Review of the physician’s orders dated 2/5/14 documented, "...clonazepam 0.5MG [milligram] TABLET (KLONOPIN) 1 TABLET BY MOUTH AT BEDTIME [t]...at bedtime" and "BID" [twice daily] was written above it."

Review of Resident #36’s medication administration records (MAR) documented the following:

a. January, 2014 - received clonazepam (Klonopin) 0.5 mg two times per day from January 1st through January 31, 2014.
b. February, 2014 - received clonazepam 0.5 mg two times per day from February 1st through February 7th, 2014 and clonazepam 0.5 mg three times per day from February 8th through February 18th, 2014. Resident #36 received clonazepam 0.5 mg one time on February 19th and 20th, 2014 and clonazepam 0.5 mg two times per day from February 21st through February 28th, 2014.
c. March, 2014 - received Klonopin 0.5 mg two times per day from March 1st through March 31st, 2014.

The pharmacist did not identify irregularities on the medication reviews.

During an interview in the staff development office on 4/1/14 at 6:10 PM, the Director of Nursing (DON) was asked about the gradual drug reduction (GDR) recommendation from the pharmacist dated January, 2014. The DON stated, "I am reviewing the orders, and the med reconciliation for Feb [February] changing it back to BID. I cannot find any documentation regarding the order for GDR...I do not see an order until 2/8/14 and that order says to increase it. The original order was written on 3/28/13 bid for..."
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<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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</table>
| F 428        | Continued From page 29  
|              | anxiety. In February, [2014] someone caught something, because the order was written over the pharmacy printed one - bid for anxiety... I cannot find any order for the GDR. Pharmacy had to have gotten it, because it printed on the next month's [February] MAR... "The DON was asked what her expectation was regarding medication reconciliation. The DON stated, "If they see something, the nurse should have called the pharmacy and questioned the order printed on the physician order sheet."

During an interview in the staff development office on 4/1/14 at 8:15 PM, the Administrator was asked who reviews the medication recommendations from pharmacy. The Administrator stated, "I get it and the DON and that's it."

| F 431        | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  
| SS=E         | The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the

| F 431 483.60 (b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS | The facility utilizes the services of a licensed pharmacist who has established 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 are maintained and periodically reconciled.

On or before 4/30/14, licensed nurses will be inserviced. The in-service will be conducted by the Director of Nursing or Designee and will include:  
- Review of the regulations  
- Review of the statement of deficiency |
Continued From page 30

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 1970 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 review of drug package inserts, observation and interview, it was determined the facility failed to ensure medications were dated when opened; failed to ensure external and internal medications and supplements were stored separately and/or failed to ensure medication storage area was kept securely locked when not in use in 3 of 6 (B hall medication cart, C/E hall medication cart and F hall even medication cart) medication storage areas.

The findings included:

1. Observations of the B hall medication cart on 4/1/14 at 11:55 AM, revealed 1 can of Jevity oral supplement, 2 bags of Hall cough drops and a tube of Nystatin topical cream stored in the same drawer. There were no partitions to separate the items.

- Review of the plan of correction
- Pharmacy has since provided proper dividers for medication cart drawers to ensure that medications are stored separately
- All Licensed Nurses will be inserviced on the proper storage of internal and external medications and dating of all medications per policy and drug packaging inserts. Inservicing will occur on hire and quarterly.
- All med carts will be locked when not in use.
- All med carts have been provided with daily sign off sheets and oncoming nurse will be required to inspect the cart to ensure proper storage and dating of medications.

All Medications have been separated and are being checked twice daily.

Beginning 4/3/14 The Administrator or designee will monitor for continued compliance through Quality Improvement
F 431 Continued From page 31

2. Observations at the C/E hall nurses' station on 3/30/14 at 11:27 AM, revealed the C/E hall medication cart was unlocked and unattended. Nurse #1 walked up to the medication cart and stated, "Oh no! Oh no!"

During an interview in the C/E hall on 3/30/14 at 11:27 AM, Nurse #1 was asked if the medication cart should be locked. Nurse #1 stated, "Yes. I'm locking it right now."

Review of an Advair Diskus insert documented, "...safety discard ADVAIR DISKUS 1 month after you remove it from the foil pouch, or after the dose indicator reads [0], whichever comes first..."

Review of a package insert for Humalog documented, "...HUMALOG... Storage and Handling... In-use Humalog vials... must be used within 28 days or be discarded, even if they still contain HUMALOG..."

Review of a package insert for Lantus documented, "...Lantus Patient Package Insert... Opened vial, either kept in a refrigerator or at room temperature, should be discarded 28 days after the first use even if it still contains LANTUS..."

Observations of the C/E hall medication cart on 4/1/14 at 8:30 AM, revealed Hydrocortisone topical cream, Lumigan ophthalmic drops, Exelon skin patches, Sureprep Skin preparation, Omeprazole oral pills, Tylenol rectal suppositories, 1 packet of Juven oral supplement powder, and Nystatin topical powder were all stored together in one drawer with no partitions. In another drawer without partitions there was audits. (See Attachment J) The audits will be completed weekly for one month and monthly for one year. The Administrator or designee will report to the QA/QI committee who will determine the frequency of further monitoring. Completion date: 4/2/14
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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 431</td>
<td>Continued From page 32</td>
<td>Prochlorperazine rectal suppositories stored together with ophthalmic and oral medications. There was 1 opened Advair diskus with no opened date written on it, 1 opened vial of Lantus with no opened date, and 1 opened vial of Humalog with no opened date. During an interview at the C/E Medication cart on 4/1/14 at 8:30 AM, Nurse #1 was asked if the Advair and the insulins should be labeled when they are opened. Nurse #1 stated, &quot;They are supposed to.&quot;</td>
<td>F 431</td>
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<td></td>
<td>F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</td>
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<td>F 441</td>
<td>SS=D</td>
<td>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</td>
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<td>F 441</td>
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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.
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<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>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<td>F 441</td>
<td>Continued From page 33</td>
<td>F 441</td>
<td>On or before 4/30/14, licensed nurses will be inserviced. The in-service will be conducted by the Director of Nursing or Designee and will include:</td>
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<td>(a) Infection Control Program</td>
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<td>• Review of the regulation</td>
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<td>The facility must establish an Infection Control Program under which it -</td>
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<td>• Review of the statement of deficiency</td>
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<td>(1) Investigates, controls, and prevents infections in the facility;</td>
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<td>• Review of the plan of correction</td>
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<td>(2) Decides what procedures, such as isolation, should be applied to an individual resident;</td>
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<td>• All licensed nurses will</td>
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<td>(3) Maintains a record of incidents and corrective actions related to infections.</td>
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<td>be inserviced on proper disposal of all biohazard materials per policy.</td>
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<td>(b) Preventing Spread of Infection</td>
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<td>• All licensed nurses will</td>
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<td>(1) When the Infection Control Program determines that a resident needs isolation to prevent</td>
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<td>be inserviced on proper cleaning and storage of syringe following administration of peg tube</td>
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<td>the spread of infection, the facility must isolate the resident.</td>
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<td>medication.</td>
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<td>(2) The facility must prohibit employees with a communicable disease or infected skin lesions</td>
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<td>All biohazard materials will be properly disposed by licensed nurses and syringes will</td>
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<td>from direct contact with residents or their food, if direct contact will transmit the disease.</td>
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<td>be cleaned appropriately.</td>
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<td>(3) The facility must require staff to wash their hands after each direct resident contact for</td>
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<td>Beginning 5/1/14 The Administrator or designee will monitor for continued compliance</td>
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<td>which hand washing is indicated by accepted professional practice.</td>
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<td>thorough Quality Improvement audits. (See Attachment D) The audits will be completed weekly</td>
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<td>(c) Linens</td>
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<td>for one month and monthly for one quarter. The Administrator or designee will report to the</td>
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<td>Personnel must handle, store, process and transport linens so as to prevent the spread of</td>
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<td>QA/QI committee who will determine the frequency of further monitoring. Completion date: 5/1/14</td>
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<td>infection.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on policy review, observation and interview, it was determined the facility failed to</td>
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<td>ensure 1 of 4 (Nurse #1) nurses observed administering medications properly disposed of</td>
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<td>biohazard material and/or failed to cleanse or rinse a used syringe after use.</td>
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F 441 Continued From page 34

The findings included:

1. Review of the facility's "Medical Waste Container" policy documented, "...Medical waste containers... Procedures... Our facility shall dispose of medical waste in accordance with current federal, state, and local statutes..."

Observations in Resident #71's room on 4/1/14 at 8:25 AM, Nurse #1 performed an accuchek on Resident #71, and then disposed of the used strip (with blood on it) in the garbage can.

During an interview in the staff development office on 4/2/14 at 10:15 AM, the Director of Nursing (DON) was asked how she expects the staff to dispose of the used glucometer strips after completion of the glucose checks. The DON stated, "Put them in the sharps [container] or a red bag... biohazard..."

2. Review of the facility's "Administering Medications through an Enteral Tube" policy documented, "...Administering Medications through an Enteral Tube... Steps in the procedure... Discard all disposable items into designated containers..."

Observations in Resident #35's room on 3/31/14 at 2:50 PM, Nurse #1 administered a medication via a percutaneous gastrostomy (PEG) tube and flushed the tube with water using a 60 cubic centimeter (cc) piston syringe. Nurse #1 then stored the syringe back in it's plastic container and placed it on Resident #35's night stand without cleansing or rinsing the syringe.

During an interview in the staff development
Continued From page 35

office on 4/2/14 at 10:15 AM, the DON was asked what she expects the nurses to do with the syringe after medication administration via a PEG tube. The DON stated, "Rinse it."

The facility must promptly notify the attending physician of the findings.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to promptly notify the physician of an abnormal urinalysis laboratory test result for 1 of 2 (Resident #71) residents identified with abnormal lab results of the 31 residents included in the stage 2 review.

The findings included:

Medical record review for Resident #71 documented an admission date of 12/3/2013 with diagnoses of Dementia, Hypertension, Anxiety, Osteoporosis, Dysphagia, Hyperlipidemia, Edema, Diabetes Mellitus Type 2, Esophageal Reflux, Generalized Pain, Insomnia, Hypertonicity of Bladder and Hypopotamia.

Review of a nurse note dated 2/19/14 documented, "...new order per [named Resident #71’s physician] UA [urinalysis] with o&a [culture and sensitivity] for altered mental status..."

Review of a urinalysis laboratory test results dated 2/19/14, documented, "...LEUKOCYTES 1+ [plus]...Reference Range...NEGATIVE..."
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<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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<tbody>
<tr>
<td>F 505</td>
<td>Continued From page 36 NITRITE POSITIVE... Reference Range... NEGATIVE... WBC [white blood cells] 4- [lo] 8... BACTERIA 3+... CULTURE, URINE PENDING... [Nurse Practitioner's (NP) initials] 02/21/14 Await culture...* Review of the urine culture results for Resident #71 documented, &quot;...DATE DRAWN 2/19/14... DATE REPORTED 02/22/2014... CULTURE SOURCE URINE... ORGANISM ESCHERICHIA COLI... [NP's initials] 03/05/14 Repeat UA C &amp; S...&quot; Review of a UA for Resident #71 documented, &quot;...DATE DRAWN 3/8/14... DATE REPORTED 03/08/2014... URINALYSIS... LEUKOCYTES TRACE... REFERENCE RANGE... NEGATIVE... NITRITE POSITIVE... REFERENCE RANGE... NEGATIVE...BACTERIA 3+...CULTURE SOURCE URINE...ORGANISM ESCHERICHIA COLI...[NP's initials] 03/10/14 Cipro 500mg [milligrams] PO [by mouth] BID [twice per day] X [times] 7 days...&quot; Review of a telephone prescriber's order dated 3/10/14 documented, &quot;...Cipro 500mg po BID X 7 days...INDICATION-DX [diagnosis] Ecoli [Escherichia Coli] in urine...&quot; During an interview at the nurses' station on 4/1/14 at 4:30 PM, Nurse #1 was asked if Resident #71 was started on an antibiotic after the 2/19/14 UA and urine culture results were received. Nurse #1 looked at medical record and stated, &quot;if there had been an antibiotic we would have had to chart it for X [days administered] amount of days. [I am] not seeing that.&quot; During an interview in the staff development...</td>
<td>F 505</td>
<td>SDC or Designee reviews labs and reports all abnormal labs level during weekday clinical meeting. Beginning 5/1/14 The Administrator or designee will monitor for continued compliance thorough Quality Improvement audits. (See Attachment F) The audits will be completed weekly for one month and monthly for one quarter. The Administrator or designee will report to the QA/QI committee who will determine the frequency of further monitoring. Completion date: 5/1/14</td>
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F 505 Continued From page 37

Office on 4/1/14 at 6:00 PM, the Director of Nursing (DON) was asked if Resident #71 was started on antibiotics when results from 2/19/14 UA and urine culture were known. The DON stated, "Cannot find where any antibiotics were ordered until the NP was notified in March."

During an interview in the hall beside the staff development office on 4/2/14 at 10:10 AM, the NP was asked when she was notified of Resident #71's abnormal UA/C&S. The NP stated, "Did not see it until 3/6/14."

During an interview in the staff development office on 4/2/14 at 3:00 PM, Nurse #3 was asked for the policy regarding the facility's timeframe for reporting abnormal laboratory results to the physician. Nurse #3 stated, "There's no written policy. We notify them as soon as the results are available to us in a timely manner, within the same shift. If they [lab results] are critical they [the laboratory] call us and we notify them [physician or NP] immediately."
<table>
<thead>
<tr>
<th>Comments/Interventions (List any comments and action taken to resolve negative findings):</th>
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Indicate:

- Yes = Yes
- N/A = N/A
- No
- Not Applicable

Date:

Information contained in this report is privileged and confidential.

E276 & E310
Hillcrest Healthcare Center
ATTACHMENT B
<table>
<thead>
<tr>
<th>Comment/Interventions (List any comments and action taken to resolve negative findings):</th>
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Waste was collected properly. 
The proper way of disposal to properly tell auditor was changed. 
Was Changed None. 
Yes, No, N/A, Y/N, and N/A Applicable. 

Initials: [Blank] 
Date: [Blank] 

Information contained in this report is privileged and confidential.

F281E P441
Hillcrest Healthcare Center
ATTACHMENT D
**Comments/Interventions** (List any comments and action taken to resolve negative findings):

<table>
<thead>
<tr>
<th>Comments/Interventions</th>
<th>Action Taken by the Nurse</th>
<th>Indicate YES, N=NO, N/A=Not Applicable</th>
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Was the skin stimuli done in an Appropriate manner?

Was the wound measured Appropriately?

Was the wound cleaned Appropriately?

Was the wound cleaned and dressing changed Appropriately?

Did the nurse observe Wound Healing?

Did the nurse observe Wound Infection?

Did the nurse observe Wound Infection and/or Wound Infection?

Did the nurse observe Wound Infection and/or Wound Infection?

* Indicate YES, N=NO, N/A=Not Applicable

**Resident's Initials:**

---

**Date:**

---

**Reviewer:**

Information contained in this report is privileged and confidential.

---

**Hillcrest Healthcare Center**

**ATTACHMENT**

---
### Comments/Interventions

(Include any comments and action taken to resolve negative findings:

| Date: | 
|------|---|

Information contained in this report is privileged and confidential.

E315 & 505

Hillcrest Healthcare Center

ATTACHMENT
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<th>Comment/Interventions (list any comments and action taken to resolve negative findings):</th>
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Information contained in this report is privileged and confidential.

Attachment G
* Indicate Y = Yes, N = No, and N/A = Not Applicable

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<tr>
<th>Area</th>
<th>Do all locked exit doors display a 15 second delay sign?</th>
<th>Is the metal container with a self-closing cover present in the designated smoking area?</th>
<th>Have there been any penetrations made in the fire wall in the past week?</th>
<th>If yes, was the material used for a barrier, fire resistant?</th>
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Comments/Interventions (List any comments and action taken to resolve negative findings):

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