<table>
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<th>F 278</th>
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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.

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 accuracy of the Minimum Data Set (MDS) related to pressure sores and diagnoses for 2 of 44 (Residents #104 and 152) sampled residents.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
**F 278** Continued From page 1 
reviewed on the stage 2 sample.

The findings included:

1. **Medical record review for Resident #104** documented an admission dated of 12/23/10 with diagnoses of Hernia, Parkinson's Disease, Dementia, Coronary Artery Bypass Graft, Hypertension, Hyperlipidemia, Osteoarthritis, Depression and Psychosis related to Parkinson's. Nurses' notes documented the following:
   a. 12/29/12 - "...Open area noted to buttock measuring 4.5x [by] 3.2 < [less than] 0.2 [centimeters], area has a hard mass noted @ [at] 5 o'clock. Dressing applied to open area @ this time... MD [Medical Doctor] aware of open area will monitor." A physician's order dated 12/29/12 documented, "clean open area c [with] NS (Normal Saline) apply Santyl-Collogen & [and] foam pad q [every] day til [until] healed."

Review of the weekly wound progress notes documented the following:
   a. 12/29/12 - date of onset "12/29/12" measures "4.5x3.2x<0.2cm [centimeter]."
   b. 1/14/13 - "6x4.5x<0.2cm, stage 2."
   c. 1/21/13 - "6x9xUNS [unstagable]."

The wound had deteriorated to a stage 2 on 1/14/13. The wound had further deteriorated to being unstagable on 1/21/13.

Observations in Resident #104's room on 4/25/13 at 10:20 AM, Licensed Practical Nurse (LPN) #2 performed wound care on Resident #104. The wound was approximately the size of a pencil eraser, and concurred with the facility's last assessed measurement of 1x1x0.8cm. stage 2.
Continued From page 2
The MDS dated 12/1/12 documented "no
wounds". The significant change MDS dated
2/25/13 documented "no wounds." The facility
failed to complete an accurate significant change
MDS that included the pressure sore.

2. Medical record review for Resident #152
documented an admission date 9/12/12 with
diagnoses of Chronic Obstructive Pulmonary
Disease, Diabetes Mellitus, Hypertension, Muscle
Weakness, Gastro Esophageal Reflux Disease,
Failure to Thrive, Vascular Dementia and
Alzheimer's Dementia with Depression. Review of
a psychiatric progress note dated 1/31/13
documented diagnoses of Vascular Dementia
with Delusions and Alzheimer's Dementia with
Depression. Review of the admission MDS dated
9/19/12 in Section N (medications) documented
(5) antianxiety indicating the number of days the
resident received antianxiety medications since
admission. The quarterly MDS dated 3/10/13 in
Section N (medications) documented (7)
antianxiety and (7) antidepressants indicating the
number of days the resident had received
antianxiety and antidepressant medications since
admission. Section I on the admission and
quarterly MDS did not include diagnoses for
depression and anxiety.

During an interview in the MDS office on 4/25/13
at 5:45 PM, the MDS Coordinator was asked
where to locate a diagnosis for a resident that
was receiving medications for depression and
anxiety. The MDS Coordinator stated, "It would
be in Section I but it is not there because I could
not find a diagnosis... so it is not there... there is
not one..."
Continued From page 3

PARTICIPATE PLANNING CARE-REVISE CP

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 policy review, medical record review, observation, and interview, it was determined the facility failed to revise the comprehensive care plan to reflect interventions to reflect dialysis, participation in care planning, Range of Motion (ROM), hospice, and rehabilitation for 5 of 44 (Residents #69, 94, 97, 132, and 165) sampled residents included in the stage 2 review.

The findings included:

1. Review of the facility's "Comprehensive Care Plan"

F 280
483.20 (d) (3), 483.10 (k) (2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CARE PLAN

Requirement:
A comprehensive care plan will 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 of 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.

Corrective Action:

1. (A) On 4/25/2013, resident #69 care plan was updated to reflect intervention if bleeding occurs.
   (B) On 4/25/2013, resident #165 care plan was updated to reflect presence of arm trough.
   (C) On 4/26/2013, resident #132 care plan was updated to reflect hospice care.
   (D) On 4/29/2013, resident #97 care plan was updated to reflect intervention for right arm contracture.

2. An audit was conducted on 4/29/2013 by the MDS Coordinator, DON, and ADON to ensure care plans reflect resident current status with appropriate interventions.

3. (A) On 4/29/2-13, an in-service was conducted by the DON with the MDS Coordinator regarding updating care plans with intervention and documentation notification to families/resident of care plan meetings.
   (B) MDS Coordinator will document notification to families/resident on the MDS/care plan progress note.

4. The Risk Management Nurse and the ADON or designee will monitor for compliance through random chart audits and report findings during the monthly Patient Care and Services meeting and quarterly during the QA Committee meeting.

Completion Date: 5/2/2013
Continued From page 4

Plan" policy documented, "...The care plan must be reviewed every 90 days... When there is a change in patient status..."

2. Review of the facility's "DIALYSIS PATIENT SERVICES" policy documented, "Care plan must include: Care of dialysis patient with emergency procedures and Potential problems.

Medical record review for Resident #69 documented, an admission date of 12/27/10 with a diagnoses of Gastritis, Right Below the Knee Amputation, Deep Vein Thrombosis of the Left Lower Extremity, Esophagitis, Diabetes Mellitus, Gastroparesis, End Stage Renal Disease, Dialysis, Peripheral Vascular Disease, Hyperlipidemia, Sacral Decubitus, Left Femur Fracture, Anemia, Obesity, Endocarditis, Seizures, Atrial Fibrillation, Hypokalemia, Chronic Dysphagia, Degenerative Joint Disease. Review of the care plan dated 3/22/13 documented, "PROBLEM / STRENGTHS"...Risk for excess bleeding related to the dialysis shunt. There were no interventions documented for emergency procedures or care of a bleeding dialysis shunt.

During an interview in the Director of Nursing's (DON) office on 4/26/13 at 9:45 AM, the DON was asked if she expected a dialysis care plan to include the risk of emergency bleeding. The DON stated, "...it should have said to apply pressure and notify the MD [medical doctor]."

3. Medical record review for Resident #94 documented an admission date of 7/11/12 with diagnoses of Anemia, Heart Failure, Anxiety Disorder, Hypertension and Cerebrovascular Accident.
F 280: Continued From page 5

During an interview in the Social Worker's office on 4/25/13 at 3:15 PM, the Social Worker (SW) was asked how are families notified for care plan meetings. The SW stated, "I don't do that the MDS coordinator does that... I have never contacted anyone just for a care plan meeting..."

During an interview in the MDS office on 4/25/13 at 3:30 PM, the MDS Coordinator was asked, where would it be documented if families are invited to care plan meetings. The MDS Coordinator stated, "I don't... I guess I need to come up with a system to show that I have attempted to contact them..."

4. Medical record review for Resident #97 documented an admission date of 2/4/13 with diagnoses of Rhabdomyolysis, Status Post (S/P) Cerebrovascular Accident (CVA) with Right Hemiparesis, Hypothyroidism, Non-Insulin Dependent Diabetes, Hypertension, History of Right Hip Fracture, and History of Proximal Atrial Fibrillation. Review of the care plan dated 2/18/13 documented, "...PROBLEMS... Requires assistance with all ADLs [activities of daily living] due to right hemiparesis, S/P CVA & [and] decline in cognition... INTERVENTIONS... OT [Occupational Therapy] to eval [evaluate] / tx [treat] as indicated PRN [as needed]..." There were no interventions on the care plan related to the diagnosis of the right arm contracture.

During an interview in the MDS Coordinator's office on 4/25/13 at 6:09 PM, the MDS Coordinator, was asked about the care plan for Resident #97. The MDS Coordinator stated, "Range of Motion should definitely be on there..."
Continued From page 6
[care plan]...

5. Medical record review for Resident #132 documented an admission date of 5/16/12 with diagnosis of Dementia, Chronic Obstructive Pulmonary Disease, Thyroid Disorder, Open Reduction Internal Fixation Left Hip, Anxiety, Hypertension, and Gastro Esophageal Reflux Disease. Review of the physician's order dated 11/19/12 documented, "...admit to [named] Hospice pt [patient] has less then 6 months to live if illness runs it's usual course..." Review of the significant change MDS dated 11/13/12 and the quarterly MDS dated 2/13/13 documented, "...Section 0. Special Treatments, Procedures, and Programs... K. Hospice Care (checked) While a Resident..." Review of the care plan dated July 2012 and updated 8/31/13 did not include hospice care.

During an interview in the MDS Coordinator's office on 4/26/13 at 8:05 AM, the MDS Coordinator was asked what should happen with the care plan when a resident is admitted to hospice. The MDS Coordinator stated, "...should collaborate with hospice..." The MDS Coordinator was asked if Resident #132's care plan had been revised to collaborate with hospice. The MDS Coordinator stated, "No, should have been..." The MDS Coordinator was asked if the care plan should be revised after a significant change. The MDS Coordinator stated, "Yes." The MDS Coordinator was asked if the resident's care plan had been updated after the significant change MDS dated 11/13/12. The MDS Coordinator stated "No."

6. Medical record review for Resident #165
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**X1 PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:**

445282

**X2 MULTIPLE CONSTRUCTION**

A. BUILDING

**X3 DATE SURVEY COMPLETED**

04/26/2013

**NAME OF PROVIDER OR SUPPLIER:**

CUMBERLAND MANOR NURSING CENTER

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

4343 ASHLAND CITY HWY

NASHVILLE, TN 37218

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<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>F 280</td>
<td>Continued From page 7 documented an admission date of 1/25/13 with diagnoses of CVA, Hypertension and Diabetes Mellitus. Review of the OT weekly note dated 3/14/13 to 3/20/13 documented, &quot;...Pt has left upper extremity arm trough on wheelchair...&quot; Review of the care plan dated 2/1/13 does not include the use of the arm trough. Observations in Resident #165's room on 4/23/13 at 3:20 PM and at 5:10 PM, revealed Resident #165 seated in his wheelchair with his left hand and forearm in an arm trough. During an interview at the nurses' station on 4/25/13 at 8:38 AM, Certified Nursing assistant (CNA) #1 was asked if Resident #165 used any supportive devices. CNA #1 stated, &quot;An arm trough...&quot; During an interview in the Director of Nursing's (DON) office on 4/25/13 at 3:30 PM, the DON was asked if she would expect Resident #165's arm trough to be included on the care plan. The DON stated, &quot;Yes.&quot;</td>
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<td>F 311</td>
<td>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADL'S</td>
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<td>SS=D</td>
<td>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. 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 provide care and services to maintain and improve the ability to ambulate with</td>
<td>F 311</td>
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<td>482.25 (a) (2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADL’s</td>
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<td>Requirement: A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</td>
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**CUMBERLAND MANOR NURSING CENTER**

**F 311** Continued From page 8  
minimal assistance for 1 of 3 (Resident #99) sample residents reviewed for community discharge of the 44 residents included in the stage 2 review.

The finding included:

Medical record review for Resident #99 documented an admission date of 1/8/13 with diagnoses of Hypertension, Diabetes Mellitus, Depression, Hypothyroidism, Esophageal Reflux Disease, Muscle Weakness, Difficulty Walking, Dysphagia, Coronary Heart Disease. Review of Minimum Data Set (MDS) 5 day assessment dated 1/15/13 documented Section G Function Activities of Daily Living G0110 documented (3) indicating two people assist, Section J Health Conditions J1800 documented (0) fails since Admission / Entry or Reentry or Prior to admission and Section O Special treatment, Procedures, and Programs 00400 documented A. Speech therapy start date 1/8/13 (5) number of days therapy was administered in the last 7 days... B. Occupational Therapy [OT] with start date 1/8/13 (5) number of days therapy was administered in the last 7 days... C. Physical therapy [PT] with start date 1/8/13 (6) number of days therapy was administered in the last 7 days. Review of quarterly MDS assessment dated 4/7/13 documented Section G Function Activities of Daily Living G0110 documented (3) indicating two people assist and Section J Health Conditions J1800 documented (1) fails since Admission / Entry or Reentry or Prior to admission.

Review of the "Physical Therapy Discharge Summary" dated 2/27/13 to 3/21/13

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<td>F 311</td>
<td>Continued From page 8</td>
<td>F 311</td>
<td>Corrective Action:</td>
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<td>minimal assistance for 1 of 3</td>
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<td>1. On 4/24/2013, resident #99 was added to PT caseload for treatment 3 times per week for 4 weeks.</td>
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<td>(Resident #99) sample residents</td>
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<td>2. On 4/26/2013, an audit was conducted of residents discharged from therapy over the last 30 days to ensure that restorative services were initiated if applicable by the therapy department.</td>
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<td>reviewed for community discharge</td>
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<td>3. On 4/26/2013, the Rehab manager conducted an in-service with all therapists regarding completion of QA contract for restorative services and the process for communicating with restorative aides.</td>
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<td>of the 44 residents included in</td>
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<td>4. The restorative nurse and rehab manager will monitor for compliance by completing random chart audits and report findings monthly during Patient Care and Services meeting.</td>
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<td>the stage 2 review.</td>
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<td>Completion Date: 5/1/2013</td>
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| ID | TAG | SUMMARY STATEMENT OF DEFICIENCIES | F 311 | Continued From page 9  
documented, "...Discharge Disposition...  
Restorative nursing..."
Review of physicians orders documented the following:  
a. 4/15/13 - "PT & [and] c/t for eval [evaluation]  
and treat l [left] knee."  
b. 4/24/13 - "PT eval & treat 3x [times] / [per] wk  
[week] x 4 weeks."
Observations in Resident #99's room on 4/23/13  
at 4:30 PM and on 4/24/13 at 8:30 AM and 10:30  
AM, revealed Resident #99 in bed.  
During an interview in the PT department on  
4/25/13 at 8:57 AM, the OT team leader stated,  
"She [Resient #99] should have been getting  
restorative It was an oversight... when a resident  
is discharged from physical therapy if indicated  
they should get restorative care and rehab quality  
assurance training contract is filled out... it did not  
get filled out... it was an over sight and she is not  
getting restorative..."
During an interview at the nurses' station on  
4/25/13 at 10:00 AM, the restorative aide stated,  
"She [Resident #99] is not getting restorative  
care..."
| ID | TAG | PROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
CROSS-REFERENCED TO THE APPROPRIATE  
DEFICIENCY) | F 311 |  
F 314  
483.25 (c) TREATMENT/SVCS TO  
PREVENT/HEAL PRESSURE SORES  
SS=S-G  
Requirement:  
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
F 314 Continued From page 10

services to promote healing, prevent infection and prevent new sores from developing.

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 provide the necessary care and treatments to prevent the deterioration or promote healing of pressure sore for 2 of 2 ( Residents #7 and 104) sampled residents reviewed with a pressure sore of the 44 residents included in the stage 2 sample. The failure to provide treatments as ordered resulted in actual harm when Resident #104's pressure sore deteriorated from a stage 2 to an unstageable pressure sore.

The findings included:

1. Review of facility's "Skin Care Guidelines" policy documented, "...Licensed nurses will complete a skin check, at a minimum of weekly or as ordered, signing off on the Medication or Treat Administration Record. If a wound is discovered, the nurse will assess the wound and notify the practitioner, documenting pertinent information (size, depth, drainage, odor, treatment orders...) in the medical record. Orders for wound care will be obtained and initiated at the time a wound is identified... Preventative measures must be implemented as soon as the patient is identified as high risk. All efforts should be made to make these interventions patient specific... Once a pressure ulcer is identified, an assessment must be documented in the Nurses Notes. The Nurses Notes must reflect that

F 314 Corrective Action:

1. On 4/25/2013, resident #7 and resident #104 received treatment to wounds according to the physicians order and completion of the care was documented on the TAR.

2. On 4/25/2013, the DON, ADON, RMN and RD reviewed all residents with wounds on current TAR to ensure documentation was present according to the physicians order. Also reviewed the residents’ medical record to ensure interventions to promote wound healing were in place.

3. On 4/25/2013, the DON in-serviced the licensed nurses regarding completing documentation on the treatment administration record after providing wound care and prompt implementation of supplements/other interventions to promote wound healing.

4. The Risk Management Nurse or designee will complete random daily dressing change observations, daily audit of treatment administration record, and audit medical records of residents with wounds daily for 3 months then weekly for 3 months, and randomly thereafter until compliance is met. Findings will be discussed weekly during skin/nutrition meeting, monthly during Patient Care and Services meeting, and quarterly during QA Committee meeting.

Completion Date: 5/1/2013
F 314  Continued From page 11
Physician and family were notified and what treatment / interventions were initiated... Daily wound treatment documentation must be completed on the Treatment Administration Record [TAR]..."

a. 12/29/12 - "...Open area noted to buttock measuring 4.5x [by] 3.2x < [less than] 0.2 [centimeters], area has a hard mass noted @ [at] 5 o'clock. Dressing applied to open area @ this time... MD [Medical Doctor] aware of open area will monitor."
b. 1/13/13 - "...MD in facility new orders implemented will monitor."

Review of the weekly wound progress notes documented the following:
a. 12/29/12 - date of onset "12/29/12" measures "4.5x3.2x<0.2cm [centimeter]."
b. 1/14/13 - "6x4.5x<0.2cm, stage 2."
c. 1/21/13 - "6x9xUNS [unstaggable]."
The wound had deteriorated to a stage 2 on 1/14/13. The wound had further deteriorated to being unstaggable on 1/21/13.

The Registered Dietician (RD) assessment dated 11/30/12 documented the "resident on regular
**NAME OF PROVIDER OR SUPPLIER**
CUMBERLAND MANOR NURSING CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
4343 ASHLAND CITY HWY
NASHVILLE, TN 37218

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<td>F 314</td>
<td>Continued From page 12 diet, gets a 2 PM snack, ice cream with lunch, and 50- [to] 100% [percent] consumed. The next RD assessment is dated 1/15/13 and documented, &quot;resident on regular diet, has a stage 2 on L [left] buttocks, Promod 30 ml QD [every day] started on 1/14/13, consumes 50-75%...&quot; Observations in Resident #104's room on 4/25/13 at 10:20 AM, Licensed Practical Nurse (LPN) #2 performed wound care on Resident #104. LPN #2 removed the old dressing from the left ischial area, cleaned, treated, and applied a new dressing to the wound with no infection control or technique concerns observed. The wound was approximately the size of a pencil eraser, circular and concur with last assessed measurements of 1x1x0.8cm stage 2. Review of the December 2012 TAR revealed no documentation of the daily treatment being done 1 of 3 (12/31/12) in December 2012. Review of the January 2013 TAR revealed no documentation of the daily treatment being done 5 of 20 days (1/5/13 through 1/8/13 and 1/10/13). During an interview in the conference room on 4/25/13 at 7:30 AM the Director of Nursing (DON) verified the pressure sore was in house developed and stated, &quot;[Named Resident #104]... Not sure why those treatments were missed will have to check into that and get back with you...&quot; During an interview on the 500 hall on 4/25/13 at 9:30 AM, LPN #1 stated, &quot;...resident would get daily wound treatments if ordered daily.&quot;</td>
<td>F 314</td>
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**CUMBERLAND MANOR NURSING CENTER**

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4/25/13 at 10:40 AM, the DON stated, "I have looked with a fine tooth comb and I do not find any documentation of those treatments... I lost my treatment nurse last July or August [2012], got another one, we gave her all kinds of inservice and education, she also worked with old treatment nurse, to be truthful I noticed in January I had a problem with wound staging. I observed the treatment nurse and questioned her, found a problem, gave her more inservice training, rechecked her and decided to replace her, currently I still do not have a treatment nurse, the nurses are doing their own treatments. I have inserviced and talked with them about documentation. I have done some chart audits and have reinserviced the nurses, and yes, I expect a daily wound treatment order to be done daily..."  
The facility failed to provide wound treatments as ordered which resulted in actual harm when Resident #104's pressure sore deteriorated.  
3. Medical record review for Resident #7 documented an admission date of 1/10/13 with diagnoses of Failure to Thrive, Alzheimer's Dementia with Behavioral Disturbances and Depression, Psychotic Disorder, Right foot Pressure Sore, History of Colon Cancer, History of Breast Cancer, Vitamin D Deficiency, Vitamin B12 Deficiency, Hypertension, Right Footdrop with multiple wounds on the right foot, Right hip Vascular Necrosis and Hemorrhage on Courmadin, History of Stroke, History of Small Bowel Obstruction, Glaucoma, Osteoporosis, Bilateral Ankle Fractures, Obstructive Sleep Apnea, History of Pleural Effusions, and History of Squamous Cell Carcinoma of the Chin. |
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<td>F 314</td>
<td>Continued From page 14 physician's order dated 1/10/13 documented, &quot;Cleanse blister top of Right foot with NS [normal saline], gently pat dry, apply gauze every M [Monday] - W [Wednesday] - F [Friday] and PRN [as needed], Clean Stage 2 Right Heel gently pat dry apply Opt foam heel protector wrap with kerlix every M-W-F and PRN. &quot; A physician's order dated 3/7/13 documented, &quot;clean rt. [right] heel with wound cleanser apply santyl cover c 4x4 &amp; foam dressing q day &amp; prn.&quot; The weekly wound progress note documented the right heel as measuring 2.2x3.6x0.8 cm on 4/23/13. The January 2013 TAR revealed a treatment not documented as being done on 1/14/13. The March 2013 TAR revealed treatments not documented as being done on 3/9/13 and 3/28/13. Observations in Resident #7's room on 4/25/13 at 9:33 AM, LPN #2 performed wound care for Resident #7. Resident #7's wound had red granulation tissue and a small amount of white connective tissue visible. During an interview in the conference room on 4/25/13 at 10:45 AM, the DON was asked about the missing documentation on the TAR. The DON stated, &quot;...The nurse should have signed off there... It might have been done and they forgot to sign it, but I know if it's not documented it's not done...&quot;</td>
<td>F 314</td>
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<tr>
<td>F 332 SS=D</td>
<td>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</td>
<td>F 332</td>
<td>483.25 (m) (1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE SS=D</td>
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medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:
Based on policy review, review of the "Medication Guide for the Long-Term Care Nurse", medical record review, observation and interview, it was determined the facility failed to ensure 1 of 9 (Nurse #3) nurses administered medications with a medication error rate of less than five percent (%). There were 4 medication errors out of 26 opportunities for error, which resulted in a medication error rate of 16%.

The findings included:

1. Review of the facility's "Medication Administration Tips" policy documented, "...12. Medication administered via feeding tube (Nasogastric or Gastrostomy)... e. Administer medications as ordered (diluting drugs as appropriate)..."

Review of "Medication Guide for the Long-Term Care Nurse", fourth edition, documented, "Administration of Medication Via Feeding Tube... Powder from crushed tablets or capsule contents should be dispersed well in 30 ml [milliliters] of water or other prescribed diluent..."

Medical record review for Resident #13 documented an admission date of 6/24/04 with diagnoses of Diabetes Mellitus with Retinopathy, Hypertension, Congestive Heart Failure, Peripheral Vascular Disease, Paranoia, Anemia, Dementia, Renal Insufficiency, Incontinence,
<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix 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 Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)</th>
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<tr>
<td>F 332</td>
<td>Continued From page 16</td>
<td>Dyslipidemia, Atropic Vaginitis, Urinary Tract Infection, Hypoglycemia, Gastro Esophageal Reflux Disease, Constipation, Bilateral Below the Knee Amputations, Anorexia with a Percutaneous Esophageal Gastrostomy. Review of the physician's orders dated 4/1/13 documented, &quot;...SPIRONOLACTONE 25MG [milligrams] ONE HALF TAB (NOTE DOSE) (12.5 MG) BY MOUTH EVERY DAY...&quot; Observations in Resident #13's room on 4/24/13 at 8:07 AM, Nurse #3, crushed Spironolactone 25 mg, Buspar 5 mg, and Hydrochlorothiazide 12.5 mg and then poured the medications powder into a syringe without diluting the powder. The administration of the wrong dose of Spironolactone and not diluting the Spironolactone, Buspar and Hydrochlorothiazide in water resulted in medication errors #1, #2 and #3. During an interview in the Director of Nursing's (DON) office on 4/26/13 at 9:40 AM, the DON stated, &quot;We teach them [nurses] to crush meds and dilute with water prior to administering... we expect them to check the 5 rights of administering meds [medications]...&quot; 2. Review of facility's &quot;COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties&quot; policy documented, &quot;Humalog...TYPICAL DOSING/COMMENTS... 15 min [minutes] before or immediately after meals.&quot; Medical record review for Resident #13 documented an admission date of 6/24/04 with diagnoses of Diabetes Mellitus with Retinopathy, Hypertension, Congestive Heart Failure, Peripheral Vascular Disease, Paranoia, Anemia,</td>
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Continued From page 17
Dementia, Renal Insufficiency, Incontinence, Dyslipidemia, Atrophic Vaginitis, Urinary Tract Infection, Hypoglycemia, Gastro Esophageal Reflux Disease, Constipation, Bilateral Below the Knee Amputations, Anorexia with a Percutaneous Esophageal Gastrostomy.

Observations in Resident #13's room on 4/24/13 at 8:07 AM, Nurse #3 drew up 5 units of Humalog insulin then administered insulin in the right upper arm. Resident #13's tray was not delivered until 8:36 AM; 31 minutes after Resident #13 received the fast acting insulin. The failure to ensure Resident #13 received food within 10 to 15 minutes after receiving Humalog insulin resulted in medication error #4.

During an interview in the Director of Nursing's (DON) office on 4/26/13 at 9:40 AM, the DON stated, "They need to get a tray or snack in 10 to 15 minutes [after receiving Humalog insulin]."

483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS

The facility must ensure that residents are free of any significant medication errors.

F 332 SS=D

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 ensure food was provided within 10 to 15 minutes after Humalog insulin was administered.

The findings included:

1. On 4/25/2013, resident #13 received Humalog insulin 5 units with prandial tray delivery according to protocol. It is also noted that resident was receiving continuous tube feedings via pump.
2. On 4/26/2013, med pass observations were conducted by the ADON, RN, and SDC.
3. On 4/26/2013, an in-service was conducted with the licensed nurses regarding medication administration as it relates to administering short acting insulin and administering medication via NG tube by the DON.
**CUMBERLAND MANOR NURSING CENTER**

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<tr>
<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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<tr>
<td>F 333</td>
<td>Continued From page 18 Review of facility's &quot;COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties&quot; policy documented, &quot;Humalog...TYPICAL DOSING/COMMENT... 15 min [minutes] before or immediately after meals.&quot; Medical record review for Resident #13 documented an admission date of 6/24/04 with diagnoses of Diabetes Mellitus with Retinopathy, Hypertension, Congestive Heart Failure, Peripheral Vascular Disease, Paranoia, Anemia, Dementia, Renal Insufficiency, Incontinence, Dyslipidemia, Atrophic Vaginitis, Urinary Tract Infection, Hypoglycemia, Gastro Esophageal Reflux Disease, Constipation, Bilateral Below the Knee Amputations, Anorexia with a Percutaneous Esophageal Gastrostomy. Observations in Resident #13's room on 4/24/13 at 8:07 AM, Nurse #3 drew up 5 units of Humalog insulin then administered insulin in the right upper arm. Resident #13's tray was not delivered until 8:38 AM; 31 minutes after Resident #13 received the fast acting insulin. The failure to serve food within 10 to 15 minutes after receiving fast acting insulin resulted in a significant medication error. During an interview in the Director of Nursing's (DON) office on 4/26/13 at 9:40 AM, the DON stated, &quot;They need to get a tray or snack in 10 to 15 minutes [after receiving Humalog insulin].&quot; During an interview at the nurses' station on 4/24/13 at 3:15 PM, Nurse #3 stated, &quot;Insulin should be 5 to 10 minutes prior to tray/food. We give snacks.&quot;</td>
<td>F 333</td>
<td>4. The RMN, ADON, and SDC will monitor for compliance through random medication observations weekly x 4, that monthly to ensure compliance is met and report findings during monthly Patient Care and Services meeting. Completion Date: 5/2/2013</td>
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<tr>
<td>F 441</td>
<td>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</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.

(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 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
3. The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.
**CUMBERLAND MANOR NURSING CENTER**

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<tr>
<td>F 441</td>
<td>Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, it was determined the facility failed to ensure infection control practices such as keeping a catheter tubing off the floor and a barrier was in place to separate clean and dirty equipment were followed to prevent the potential spread of infections. The findings included:</td>
<td>F 441</td>
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1. Medical record review for Resident #6 documented an admission date of 9/27/11 with diagnoses of Chronic Obstructive Pulmonary Disease, Anxiety, Asthma, History of Bladder Cancer with Urostomy, Neuropathy and Adjustment Disorder with Depressed Mood. Review of urine culture and sensitivity (C&S) reports dated 4/13/12, 7/11/12, and 9/30/12 documented, "...ESCHERICHIA COLI... Macrodantin 100mg [milligram] tid [three times a day] X [times] 7 days..."

Observations in Resident #6's room on 4/23/13 at 5:02 PM and 4/24/12 at 7:52 AM, revealed the catheter tubing was laying on the floor.

During an interview in the Director of Nursing's (DON) office on 4/25/13 at 3:38 PM, the DON was asked what staff should do if staff see the catheter tubing on the floor. The DON stated, "Change the catheter bag."

2. Observations in the 500 hall oxygen storage room on 4/23/13 at 11:00 AM, revealed full clean oxygen tanks in the full rack and empty oxygen tanks in the empty rack, 5 dirty garbage cans, a
F 441 Continued From page 21
biohazard refrigerator with urine and test tubes and a hopper sink/commode. There is a piece of wood approximately 1 inch by 1 inch attached to the floor. The clean oxygen was stored in with the dirty items.

During an interview at the nurses station on 4/25/13 at 10:40 AM, Nurse #1 was asked about the 500 hall oxygen storage room. Nurse #1 stated, "Has unused oxygen tanks in the back of the room separated by a wood barrier, the front of the room has a bio hazard refrigerator for specimens, we put feeding poles in there, there is a hopper in there also..."