**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.

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 review of the "National Pressure Ulcer Advisory Panel [NPUAL] Updated Staging System", review of the facility's "The Wound Care Pocket Guide", medical record review and interview, it was determined the facility failed to determine stage for "4/2/12".

---

**RECEIVED**

This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.

---

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

![Signature]

**TITLE**

![Title]

04/24/12

---

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 50 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.
<table>
<thead>
<tr>
<th>Date Survey Completed</th>
<th>04/12/2012</th>
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</thead>
</table>

**STANDARD OF CARE AND PLAN OF CORRECTION**

### F 278

**Resident** assessments will accurately reflect the resident status.

1. Nurse #2 received inservice education by DON/ wound therapy consultant on accurate staging of wounds.

2. Current licensed nurses received inservice education by wound therapy consultant on accurate staging of wounds.

3. DON/UM/RN Supervisors will view new wounds on admission/development of wound. Two nurses will sign audit form indicating all wounds are staged accurately.

4. Results of audit forms will be presented to the QA committee monthly X 3 months to assess the effectiveness of plan.

**Dickson Health and Rehab**

901 N Charlotte
Dickson, TN 37055

**Provider's Plan of Correction**

**(Each corrective action should be cross-referenced to the appropriate deficiency)**

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>TAG</th>
<th>Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LEO identifying information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 278</td>
<td>Continued From page 1</td>
<td>accurately assess residents with pressure ulcers for 1 of 20 (Resident #52) sampled residents reviewed of the 29 residents in the Stage 2 review.</td>
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<td></td>
<td>The findings included:</td>
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<td></td>
<td>Review of the “National Pressure Ulcer Advisory Panel Updated Staging System” dated February 2007 documented, “Pressure Ulcer Stages… Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown, or black) in the wound bed…”</td>
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<tr>
<td></td>
<td>Medical record review for Resident #52 documented an admission date of 8/12/11 with diagnoses of Fracture of the Femur, Edema, Mental Disorder, Esophageal Reflux, Anxiety, Depressive Disorder, Atherosclerosis, Hypertension and Hyperlipidemia. Review of the care plan dated 11/2/11 documented “...Unstageable area R [right] outer foot bony prominence area…”</td>
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<tr>
<td></td>
<td>Review of the &quot;Non [the word &quot;non&quot; with a line drawn through] Pressure Skin Condition Record&quot; dated 11/2/11 documented, &quot;...Date First Observed 11/2/11 Site Location... R [right] outer foot... Measurements Length (cm) [centimeters] 2.4 x [by] Width (cm) 1.8... Wound Bed... blackishpurple Surrounding Skin Normal for Skin...&quot; Review of the wound bed documentation revealed there was no documentation of the wound having eschar or slough.</td>
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<tr>
<td></td>
<td>Review of the facility’s &quot;The Wound Care Pocket Guide&quot; documented, &quot;...Pressure Ulcer Stages...&quot;</td>
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</tbody>
</table>
F 278: Continued From page 2

- Unstageable Full thickness tissue loss in which the base of the wound is covered by slough and/or eschar...

- During an interview in the chapel on 4/11/12 at 11:42 AM, Nurse #2 showed the surveyor the "Wound Care Pocket Guide" when asked if she had correctly staged the pressure ulcer. While looking at the "Wound Care Pocket Guide", Nurse #2 stated, "...I know a deep tissue injury is dark purple like that... It was deep purple with no covering, just skin. Now that I am talking to you, no it [the wound] was not [unstageable]... It was a deep tissue injury...

F 278: 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.26; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).
<table>
<thead>
<tr>
<th>ID PREFIK TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PROCESSED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIK TAG</th>
<th>PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X3) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 279</td>
<td>Continued From page 3</td>
<td>F 279</td>
<td>An Interim Plan of Care will be completed within 24 hours of an admission nursing assessment completed on all admissions.</td>
<td>05-05-12</td>
</tr>
<tr>
<td></td>
<td>This REQUIREMENT is not met as evidenced by:</td>
<td></td>
<td>1. Nurse completing Interim Plan of Care for Resident #67 received inservice by MDS Coordinator/DON regarding completing Interim Plan of Care.</td>
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<tr>
<td></td>
<td>Based on policy review, medical record review and interview, it was determined the facility failed to develop a care plan to reflect bowel incontinence, impaired cognition, decreased activity of daily living (ADL) ability and risk for skin breakdown for 1 of 20 (Resident #67) sampled residents reviewed of the 29 residents in the Stage 2 review.</td>
<td></td>
<td>2. Current licensed nursing staff was inserviced on proper completion of Interim Plan of Care by MDS Coordinator/DON.</td>
<td></td>
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<tr>
<td></td>
<td>The findings included:</td>
<td></td>
<td>3. DON/MDS Coordinator/UM/RN Supervisors will monitor completion of Interim Plan of Care 5 X weekly when auditing admission charts.</td>
<td></td>
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<tr>
<td></td>
<td>Review of the facility's &quot;Care Plans - Comprehensive&quot; policy documented, &quot;...An individual comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident...&quot;</td>
<td></td>
<td>4. Results of audits will be presented to the QA committee monthly X3 months to assess effectiveness of plan.</td>
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<tr>
<td></td>
<td>Medical record for Resident #67 documented an admission date of 2/24/12 with diagnoses of Congestive Heart Failure, Alzheimer's Dementia, Hypertension, Intestinal Infection of Clostridium difficile, Muscle Weakness, Dysphagia, Failure to Thrive, and Bowel Incontinence. Review of the care plan dated 2/24/12 did not document any interventions for bowel incontinence, impaired cognition, decreased ADLs, or risk for skin breakdown.</td>
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<tr>
<td></td>
<td>During an interview in the Director of Nursing's (DON) office on 4/11/12 at 3:30 PM, the DON was asked which areas on the admission care plan were appropriate problem areas for interventions for Resident #67. The DON</td>
<td></td>
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</table>
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CJA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<tbody>
<tr>
<td>445477</td>
<td>A. BUILDING</td>
<td>04/12/2012</td>
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<tr>
<td></td>
<td>B. WING</td>
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</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

DICKSON HEALTH AND REHAB

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

961 N CHARLOTTE
DICKSON, TN 37055

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>(X5) ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X6) COMPLETION</th>
</tr>
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<tbody>
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<td>(EACH DEFICIENCY MUST BE SPECIFIED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td></td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td>DATE</td>
</tr>
</tbody>
</table>
| F 279   | Continued From page 4 reviewed the care plan and stated, "She [Resident #67] would have needed care for incontinence of bowel, ADLs, dementia, fluids because of the CHF [Congestive Heart Failure]. None of these are checked, but should have been."
| F 279   | F 279                             |         | See page 6                    |                 |
| F 280   | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVIEW CP | F 280   | See page 6                    |                 |
| SS=O    | 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 for falls and pressure ulcer for 2 of 20 (Residents #48 and 52) sampled.
F 280  Continued From page 5

residents reviewed of the 29 residents in the
Stage 2 review.

The findings included:

1. Review of the facility's "Care Plans -
Comprehensive" policy documented,
"...Assessments of residents are ongoing and
care plans are revised as information about the
resident and the resident's condition change..."

2. Medical record review for Resident #48
documented an admission date of 1/27/10 with
diagnoses of Alzheimer's Disease, Vascular
Dementia, Diabetes Mellitus Type II, Depression,
Hypertension and Trigeminal Neuralgia. Review of
the "Nurse's Notes" dated 2/16/12 documented
Resident #48 was found in the floor in the North
Hail bathroom. There was no documentation the
current care plan had been revised with a
different intervention after the fall. Review of the
"Daily Skilled Nurse's Note" dated 4/8/12
documented Resident #48 experienced a fall
while pushing herself up out of a wheelchair
unassisted. There was no documentation the
current care plan had been revised with a
different intervention after the fall.

During an interview in the chapel on 4/11/12 at
4:45 PM, Nurse #4 was asked if the care plan
had been revised with interventions after the fall
on 2/16/12 and 4/8/12. Nurse #4 stated, "I don't
see that any interventions were added..."

3. Medical record review for Resident #52
documented an admission date of 8/12/11 with
diagnoses of Fracture of the Femur, Edema,
Mental Disorder, Esophageal Reflux, Anxiety,

Comprehensive careplans will be
revised to reflect current resident
status.

1. Resident #48-Careplan revised
to include falls with
appropriate interventions.
Resident #52-Careplan revised
to include interventions for
stage II wound, left buttock.

2. Careplans of each resident
with falls and wounds have
been revised to include
interventions to prevent falls
and measures to prevent/treat
wounds.

3. MDS
Coordinator/DON/UM/RN
Supervisor will review
Care plans with falls and
wounds weekly X 4 weeks the
monthly X 2 months.

4. Results of the above reviews
will be presented to the QA
committee monthly X 3
months to assess effectiveness
of the plan.
F 280. Continued From page 6

Depressive Disorder, Atherosclerosis, Hypertension and Hyperlipidemia. Review of a physician’s order dated 4/4/12 documented, “...hydrocolloid apply to L [left] buttck Stage II change 4d [every 4 days] at [and] pm [as needed]...” Review of the care plan dated 2/21/12 revealed the care plan was not revised to include interventions for the Stage II wound to the left buttock.

Observations in Resident #52’s room on 4/11/12 at 8:50 AM, revealed Resident #52 sitting up in bed on an airflow mattress and a bed alarm in use.

During an interview in the Director of Nursing’s office on 4/12/12 at 8:10 AM, Nurse #4 was asked if the care plan was revised for the wound identified on 3/25/12. Nurse #4 stated, “No, ma’am. It’s [wound] not on the care plan.”

F 282. The services provided by the facility will be provided by qualified persons in accordance with each residents written plan of care.

1. Resident #24 is receiving incontinence care consisting of check q 2 hours and pm for incontinence. Pericare after each episode of incontinence provided.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation and interview, it was determined the facility failed to follow interventions on the care plan for incontinence care for 1 of 20 (Resident #24) sampled residents reviewed of the 29 residents in the Stage 2 review.
F 282  Continued From page 7
The findings included:

Medical record review for Resident #24 documented an admission date of 6/8/11 with diagnoses of Hypertension, Congestive Heart Failure, Muscle Weakness, Atherosclerosis, Urinary Tract Infection, Altered Mental Status and Coronary Artery Disease. Review of the Admission Nursing Assessment dated 6/29/11 documented Resident #24 was incontinent of urine and wakes to toilet. Review of the admission Minimum Data Set (MDS) with an assessment reference date of 7/5/11 documented, "...Section H Bladder and Bowel... Trial of a toileting program... No... Urinary incontinence... Frequently incontinent..." Review of the quarterly MDS with an assessment reference date of 3/1/12 documented, "Section H Bladder and Bowel... Current toileting or trial... No... Urinary incontinence... Occasionally incontinent..." Review of the monthly summary nurses notes dated 3/14/12 documented, "Continence... Bladder Continence and Patterns... Usually continent... Pads/ Briefs used... All times..."

Review of the care plan revised 3/6/12 documented, "Problem requires limit/ Extensive assist with ADL's [activities of daily living]... Goal Will be clean, dry, and odor free... Interventions Check for incontinence q [every] 2 hrs [hours]... and pm [as needed] Provide pericare after each episode of incontinence..."

Observations in Resident #24's room on 4/9/12 at 4:40 PM, revealed Resident #24 seated in a wheelchair in her room. The resident stated she wears a pullup during the day and night due to
### F 282
Continued From page 8
being incontinent of urine.

Observations and interview in the west hall on 4/11/12 at 8:30 AM, revealed Resident #24 seated in a wheelchair holding clean clothes and a pullup in her lap. Resident #24 stated, "I wet the bed... I had just one pull up and it didn't hold. My bed is wet." Observations in Resident #24's room revealed the sheet on the bed had a large yellow circle on the middle of the sheet. The sheet was covered with a throw blanket. There was no incontinence pad on the bed.

Observations in Resident #24's room on 4/11/12 at 9:45 AM and 11:25 AM, revealed the mattress was covered with a sheet on the bed which had a large yellow circle on the middle of the sheet. The sheet was covered with a throw blanket.

During an interview in the west hall on 4/10/12 at 8:40 AM, Certified Nursing Assistant (CNA) #2 was asked if Resident #24 was incontinent of urine. CNA #2 stated, "She is incontinent of urine. She [Resident #24] changes herself though. She wears a pullup. She is always wet. She knows when to change, but she is always wet. She can get another pullup when she asks for it." CNA #2 was asked how often do you check on her for toileting needs. CNA #2 stated, "She changes herself. We just give her a pullup if she asks for it."

### 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
Residents who enter the facility are notm going to receive appropriate treatment and services to prevent urinary tract infections and to restor as much normal bladder function as possible.

1. Residents #7, #18 and #63 are receiving appropriate catheter care as ordered. Res #24 is receiving appropriate incontinence care and participating in an appropriate toileting program as ordered.

2. Current residents with indwelling catheters are receiving appropriate catheter care. Currentl with incontinence of bowel/bladder are receiving appropriate incontinence care.

3. Nursing staff inserviced by DON/UM on appropriate procedures for placement of indwelling catheter tubing. Nursing staff inserviced by DON to begin appropriate toileting program when changes in continence occur.

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<table>
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<tr>
<th>F 315</th>
<th>Continued From page 10</th>
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<tbody>
<tr>
<td></td>
<td>assessment, nursing staff will seek and document details related to continence. Relevant details include: a. Voids patterns... 7. The staff and physician will summarize an individual's continence status...&quot;</td>
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<tr>
<td></td>
<td>Observations in the east hall on 4/11/12 at 3:25 PM, revealed Certified Nursing Assistant #1 pushing the wheelchair for Resident #7 with the Foley Catheter tubing dragging on the floor.</td>
</tr>
<tr>
<td>3.</td>
<td>Medical record review for Resident #18 documented an admission date of 3/29/10 with diagnoses of Late effects of Cerebrovascular Accident, Amputation of Foot, Chronic Airway Obstruction, General Osteoarthritis, Peripheral Vascular Disease, Chronic Ischemic Heart Disease, Hypertension, Pressure Ulcer Low Back and Benign Prostatic Hypertrophy without Urinary Obstruction. Review of a physician's order dated 3/1/12 documented, &quot;...SUPRAPUBIC CATH #20Fr / 30CC SUBLUB 0.01% (due to) URINARY RETENTION, CHANGE BSB [bedside bag] EVERY 2 WEEKS, CHANGE CATH MONTHLY AND AS NEEDED, FOLEY CATH CARE EVERY SHIFT...&quot; Review of the care plan with revision date of 2/11/11 documented, &quot;...risk for UTI...&quot;</td>
</tr>
</tbody>
</table>

<p>| F 315 | 4. Results of competency observation will be presented to QA committee monthly X 3 months to assess effectiveness of system. |</p>
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Observations in the east hall on 4/11/12 at 10:23 AM, revealed Resident #18 seated in an electric wheelchair with the catheter tubing laying on top of the wheelchair wheel while the resident was moving down the hallway.</td>
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<td>During an interview in the chapel on 4/11/12 at 3:30 PM, Nurse #2 was asked if it was acceptable for the tubing of a suprapubic catheter to be laying on the wheel of a wheelchair as the chair is being propelled down the hall. Nurse #2 stated “No.”</td>
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<td>4. Medical record review for Resident #63 documented an admission date of 12/9/10 with diagnoses of Mental Disorder, Hypertension, Acute Cholecystitis, Alzheimer’s Disease and Renal Failure. Review of a physician’s order dated 3/1/12 revealed, &quot;...F/C #18 FR/10cc D/T URINARY RETENTION... SUPRAPUBIC CATH CARE EVERY SHIFT...”</td>
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<td>Observations in the chapel on 4/11/12 at 9:00 AM, revealed Resident #63 propelling self in wheelchair with Foley catheter in a privacy bag hanging behind the wheelchair and the Foley catheter tubing under the chair on the floor dragging along as the wheelchair moved.</td>
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<tr>
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<td></td>
<td>Observations in the east hall on 4/11/12 at 2:30 PM, revealed Resident #63 being propelled down the hall in the wheelchair with his catheter tubing dragging on the floor.</td>
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</table>
Dickson Health and Rehab

F 315 Continued From page 12

During an interview in the chapel on 4/11/12 at 3:30 PM, Nurse #2 was asked if it was acceptable for the catheter tubing to be on the floor. Nurse #2 stated, "No."

5. Medical record review for Resident #24 documented an admission date of 5/8/11 with diagnoses of Hypertension, Congestive Heart Failure, Atherosclerosis, Urinary Tract Infection, Muscle Weakness, Altered Mental Status and Coronary Artery Disease. Review of the admission nursing assessment dated 8/28/11 documented Resident #24 was incontinent of urine and wakes to toilet. Review of the admission Minimum Data Set (MDS) with an assessment reference date of 7/8/11 documented, "...Section H Bladder and Bowel... Trial of a toileting program... No... Urinary incontinence... Frequently incontinent..." Review of the quarterly MDS with an assessment reference date of 3/1/12 documented, "Section H Bladder and Bowel... Current toileting or trial... No... Urinary incontinence... Occasionally incontinent..." Review of the monthly summary nurses' notes dated 3/14/12 documented, "Continence... Bladder Continence and Patterns... Usually continent... Pads/Briefs used... All times..." Review of the care plan revised 3/6/12 documented, "Problem requires limit / Extensive assist with ADL's [activities of daily living]... Goal Will be clean, dry, and odor free... Interventions Check for Incontinence q [every] 2 hrs [hours] and p/n [as needed] Provide pericare after each episode of incontinence..."

Observations in Resident #24's room on 4/9/12 at 4:40 PM, revealed Resident #24 seated in a wheelchair in her room. The resident stated she...
F 315 Continued From page 13
wears a pullup during the day and night due to being incontinent of urine.

Observations and interview in the west hall on 4/11/12 at 8:30 AM, revealed Resident #24 seated in a wheelchair holding clean clothes and a pullup in her lap. Resident #24 stated, "I wet the bed... I had just one pull up and it didn't hold. My bed is wet." Observations in Resident #24's room revealed the sheet on the bed had a large yellow circle on the middle of the sheet. The sheet was covered with a throw blanket. There was no incontinence pad on the bed.

Observations in Resident #24's room on 4/11/12 at 9:45 AM and 11:25 AM, revealed the mattress was covered with a sheet on the bed which had a large yellow circle on the middle of the sheet. The sheet was covered with a throw blanket.

During an interview in Resident #24's room on 4/11/12 at 5:55 PM, Nurse #5 was asked to examine the sheet on the bed for cleanliness. Nurse #5 removed the throw and stated, "That circle is definitely a stain of urine. She [Resident #24] had wet the bed. Should have been an incontinence pad on the bed to protect the sheet..."

During an interview in the west hall on 4/10/12 at 8:40 AM, Certified Nursing Assistant (CNA) #2 was asked if Resident #24 was incontinent of urine. CNA #2 stated, "She is [incontinent of urine]. She [Resident #24] changes herself though. She wears a pull up. She is always wet. She knows when to change, but she is always wet. She can get another pull up when she asks for it." CNA #2 was asked how often do you
F 315 Continued From page 14

check on her [Resident #24] for toileting needs. CNA #2 stated, "She changes herself. We just give her a pull up if she asks for it."

During an interview in the north nurses' station on 4/10/12 at 4:10 PM, Nurse #4 was asked if an incontinence assessment had been completed for Resident #24. Nurse #4 stated, "On admission nursing does an assessment. We had a company come in and do an assessment but that was before she came. She has not had the complete assessment..."

During an interview in the east hall on 4/11/12 at 4:00 PM, Nurse #3 was asked if Resident #24 had participated in a toileting program. Nurse #3 stated, "She never had a toileting program since she came. She is incontinent mostly at night... She has not been assigned to have a formal toileting program. I don't think voiding patterns were ever assessed on her..."

F 329

433.250 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
F 329  Continued From page 15

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.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to ensure residents were free from unnecessary medications for 2 of 10 (Residents #24 and 32) sampled residents reviewed of the 29 residents in the Stage 2 review.

The findings included:

1. Medical record review for Resident #24 documented an admission date of 6/8/11 with diagnoses of Hypertension, Congestive Heart Failure, Atherosclerosis, Urinary Tract Infection, Muscle Weakness, Altered Mental Status and Coronary Artery Disease. Review of the physician’s recertification orders documented, 
   "...LATANOPROST 0.005% [percent] DROPS FOR XALATAN...1 DROP AFFECTED EYE TWICE DAILY (POOR VISION)..."

During an interview at the north hall nurses’ station on 4/10/12 at 3:10 PM, Nurse #4 was asked if there was a diagnosis for the Latanoprost eye drops. Nurse #4 stated, "She
F 329  Continued From page 16

[Resident #24] gets the Xalatan [Latanoprost eye drops] for poor vision to the affected eye. The poor vision is probably a result of something else. There is probably a more definite diagnosis. The facility was unable to provide a documented diagnosis for the use of the Latanoprost eye drops.

2. Medical record review for Resident #32 documented an admission date of 3/15/12 with diagnoses of Urinary Tract Infection, Peripheral Vascular Disease, Peripheral Neuropathy, Gastro Esophageal Reflux Disease, Hyperlipidemia, Hypertension, Coronary Artery Disease, Depression and Chronic Obstructive Pulmonary Disease. Review of the physician's recertification orders dated 4/5/12 documented, "...TIMOLOL MALEATE 0.5% DROPS... ONE DROP EACH EYE EVERY DAY..." The facility was unable to provide documentation of a diagnosis for the indication/need for the eye drops.

During an interview in the chapel on 4/11/12 at 6:09 PM, Nurse #2 was asked if there was a diagnosis for the Timolol eye drops. Nurse #2 stated, "She [referring to the Director of Nursing] asked the resident and he said the drops are for glaucoma."

F 428 483.60(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.
This REQUIREMENT is not met as evidenced by:

- Based on medical record review, pharmacy review and interview, it was determined the pharmacist failed to identify and report the need of a diagnosis for the use of Xalatan eye drops for 1 of 10 (Resident #24) sampled residents reviewed of the 29 residents in the Stage 2 review.

The findings included:

Medical record review for Resident #24 documented an admission date of 6/8/11 with diagnoses of Hypertension, Congestive Heart Failure, Atherosclerosis, Urinary Tract Infection, Muscle Weakness, Altered Mental Status, and Coronary Artery Disease. Review of the physician's recertification orders documented, "...LATANOPROST 0.005% [percent] DROPS FOR XALATAN... 1 DROP AFFECTED EYE TWICE DAILY (POOR VISION)."

Review of the facility's Consultant Pharmacist's "Consultation Report" for January, February and March 2012 reported no irregularities in medication regimen. The pharmacy reviews had no documentation that the facility needed a diagnosis for the use of Xalatan eye drops.

During an interview at the north hall nurses' station on 4/10/12 at 3:10 PM, Nurse #4 was asked if there was a diagnosis for the
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>TAG</th>
<th>PROVIDER’S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F428</td>
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<td>Continued From page 18</td>
<td>F428</td>
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<td>Latanoprost eye drops. Nurse #4 stated, “She [Resident #24] gets the Xalatan [Latanoprost eye drops] for poor vision to the affected eye. The poor vision is probably a result of something else. There is probably a more definite diagnosis.” The facility did not provide a diagnosis for the Latanoprost eye drops.</td>
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<td>F431</td>
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<td>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 facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to</td>
<td>F431</td>
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<td>See page 20</td>
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<td>ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES</td>
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<td>F 431</td>
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<td>F 431</td>
<td>The facility will destroy or return all discounted, outdated/expired drugs or biological in accordance with pharmacy return/destruction guidelines.</td>
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<td></td>
<td>have access to the keys.</td>
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<td>1. Expired Prevacid, expired culture tubes, expired glucose solution and expired foam tipped sterile swab were destroyed.</td>
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<td>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</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 ensure proper storage of medications and biologicals by not removing expired medications and laboratory supplies from 3 of 8 (east hall medication room, north hall medication room and north hall medication cart) medication storage areas and the east hall nurses’ station.</td>
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<td>The findings included:</td>
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<td>1. Review of the facility’s &quot;LTC [Long Term Care] Facility’s Pharmacy Services and Procedures Manual 5.3 Storage and Expiration Dating of Drugs, Biologicals, Syringes, and Needles&quot; policy documented, &quot;...13. The facility should destroy or return all discounted, outdated/expired, or deteriorated drugs or biologicals in accordance with Pharmacy return/destruction guidelines...&quot;</td>
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<td>2. Observations in the east hall medication room on 4/12/12 at 8:52 AM, revealed Prevacid 24 hour</td>
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<td>(X4) ID TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID PREFIX TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td>DATE COMPLETION</td>
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<td>F 431</td>
<td>Continued From page 20 (hr) 15 milligrams (mg) - 1 bottle of 14 capsules with an expiration date of 8/2011. Nurse #2 stated, &quot;Yes, it's [Prevacid] expired.&quot;</td>
<td>F 431</td>
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<td>04/12/2012</td>
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3. Observations in the north hall medication room on 4/12/12 at 9:10 AM, revealed five culture transport system for aerobes and anerobes; four tubes had an expiration date of 7/10 and one tube had an expiration date of 6/11.

During an interview in the north hall medication room on 4/12/12 at 9:10 AM, Nurse #3 was asked if the culture swabs were expired. Nurse #3 stated, "Yes."

4. Observations of the north hall medication cart revealed Glucose control solution was stored past the expiration date of 12/19/11.

During an interview at the north hall nurses' station on 4/12/12 at 9:22 AM, Nurse #1 stated, "We go by the expiration on the box."

During an interview in the chapel on 4/12/12 at 9:22 AM, Nurse #1 reviewed the manufacturers insert for expiration of glucose solution and stated, "90 days, I'll get rid of that one."

5. Observations in the east hall nurses' station on 4/12/12 at 9:20 AM, revealed a sterile foam tipped swab with an expiration date of July 2011.

During an interview in the east hall nurses' station on 4/12/12 at 9:20 AM, Nurse #2 was asked about the swab being stored past the expiration date. Nurse #2 confirmed the swab was expired by affirmatively shaking her head side to side, indicating yes it was expired.
6. During an interview in the chapel on 4/12/12 at 10:30 AM, the Director of Nursing (DON) was asked what her expectations of the staff were for expired medications and laboratory supplies. The DON stated, "...Get rid of it [expired items]..."