<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X9) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 157</td>
<td>483.10(b)(11) NOTIFY OF CHANGES</td>
<td>SS=D</td>
<td>(INJURY/DECLINE/ROOM, ETC)</td>
<td>This plan of correction is submitted as required under State and Federal law.</td>
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</tbody>
</table>

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention: a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment), or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(a)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:

<table>
<thead>
<tr>
<th>LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE</th>
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<tr>
<td>[Signature]</td>
<td>[Name]</td>
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JUN 10 2013

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 157. Continued From page 1 to notify the physician of a severe weight loss for 1 of 3 (Resident #167) sampled residents reviewed of the 15 residents with nutritional concerns.

The findings included:

Review of the facility's "DOCUMENTATION GUIDELINES" policy documented, "...Weights... any unusual variation in weight... report to licensed nurse who reports to physician and dietitian..."

Medical record review for Resident #167 documented an admission date of 12/11/12 and discharge date of 3/21/13 with diagnoses of Status Post (S/P) Right Hip Fracture and Repair, Difficulty Walking, History of Falls, Osteoarthritis, History of Breast Cancer, Peripheral Neuropathy, Hyperlipidemia, Communication Deficit, Lack of Coordination, History of Right Mastectomy, Gastro Esophageal Reflux Disease, Anemia, and Arhythmia. Review of a dietary note dated 12/18/12 documented, "...Weight records indicate 7# [pounds] (5.9% [percent]) weight loss since admission... Mini Nutrition Assessment (MNA) completed with a score indicating malnutrition... Recommend: med pass supplement with each med [medication] pass for additional calories and protein..." A dietary note dated 1/8/13 documented, "...Weight records indicate pt [patient] has lost 12# (9.7%) since admission... Mini Nutrition Assessment score indicates malnutrition... pt [patient] reports that she has not tried the med pass supplement yet." Review of Resident #167's weight records documented, 12/11/12 - 116#, 12/18/12 - 112#, 12/28/12 - 109.6#, 12/31 - 105.8# and 1/8/13 - 107.4#.

The facility will also promptly notify the resident and, if known, the resident’s legal representative or interested family member when there is a change in room or roomate assignment as specified in 483.15 (e) (2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b) (1) of this section.

The facility will record and periodically update the address and phone number of the resident's legal representative or interested family member.

DON and Registered Dietitian were counseled 6/3/13 by administrator on ensuring the physician is notified of the condition of a patient, when it is medically indicated.

Completed review of the medical record for resident #167 was competed 6/4/13 by DON and Registered Dietitian.

DON and Registered Dietitian were inserviced by Administrator 6/3/13 regarding systemic approach of Registered Dietitian notifying physician of the condition of a patient with nutritional concerns and weight loss.

Effective 6/3/13 Registered Dietitian will notify physicians of the condition of a patient with nutritional concerns and weight loss.
F 157

Continued From page 2

There was no documentation in the medical record that the physician had been notified of Resident #167's 10% weight loss.

During an interview in the conference room on 5/22/13 at 11:55 AM, the Registered Dietitian (RD) stated, "...nurses notify MD [Medical Doctor] of weight loss... they go by weights they document on the flow sheet..."

During an interview in the conference room on 5/22/13 at 11:58 AM, the Director of Nursing (DON) was asked if the nurses are required to notify the physician when there is a significant or severe weight loss. The DON stated, "Yes... Nurses are required to notify the doctor of weight loss... The doctor is notified by fax by the nurses... I couldn't locate a fax for [named Resident #167's weight loss]. They [nurses] didn't document it..."

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

Registered Dietitian and/or DON will begin QA process week of 6/10/13 and will review the medical record of patients with nutritional concerns and weight loss for notification of physician.

QA process will continue x 4, then report to QA committee. If standards are not met, follow-up will be completed until all criteria is acceptable.

F 278

The assessment will accurately reflect the resident's status.

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

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

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

Registered Dietitian was counseled 6/3/13 by Administrator on ensuring the MDS accurately reflects the resident's status.
F 278  Continued From page 3

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 policy review, medical record review, observation, and interview, it was determined the facility failed to the Minimum Data Set (MDS) was complete and accurate for nutritional status for 1 of 3 (Resident #167) sampled residents reviewed of the 15 residents with nutritional concerns.

The findings included:

Review of facility's "Long-Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 October, 2012" policy documented, "...Definitions PHYSICIAN - PRESCRIBED WEIGHT LOSS REGIMEN A weight reduction plan ordered by the resident's physician with the care plan goal of weight reduction. May employ a calorie-restricted diet or other weight loss diets and exercise. Also includes planned diuresis. It is important that weight loss is intentional... Coding Instructions Code 1, yes on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% [percent] or

Complete review of the medical record for resident #167 was completed 6/4/13 by DON and Registered Dietitian to ensure accuracy of assessment.

MDS assessments 12/18/12 and 12/25/12 on resident #167 were corrected by Registered Dietitian and MDS Coordinator 6/6/13.

Registered Dietitian will begin QA process week of 6/10/13 and will review a sample of MDS assessments to ensure the assessment accurately reflects the resident's status.

QA process will continue weekly x 4, then report to QA committee. If standards are not met, follow-up will be completed until all criteria is acceptable.
F 278  Continued From page 4

more in the past 30 days or 10% or more in the
last 180 days, and the weight loss was planned
and pursuant to a physician’s order... To code
K0300 as 1, yes, the expressed goal of the weight
loss diet or the expected weight loss of edema
through the use of diuretics must be
documented..."

Medical record review for Resident #167
documented an admission date of 12/11/12 with
diagnoses of status post Right Hip Fracture and
Repair, Difficultly Walking, History of Falls,
Osteoarthitis, Peripheral Neuropathy, History of
Breast Cancer, Hyperlipidemia, Communication
Deficit, Lack of Coordination, History of Right
Mastectomy, Gastroesophageal Reflux Disease,
Anemia, and Arrhythmia. Review of the vital sign
flow sheet documented the following weights:
12/11/12 - 119 pounds (#) admission weight,
12/13/12 - 112#, 12/26/12 - 109.6# (7.5% weight
loss in 15 days), 1/2/13 - 106.6#, 1/8/13 - 107.4#,
1/17/13 - 105.6# (10% weight loss in a month),
1/22/13 - 104.4#, 2/1/13 - 104#, 2/23/13 - 104.4#,
2/12/13 - 106.4# and 3/8/13 102.6#. The
physician's admission orders and progress note
dated 12/11/12 documented orders for Calcium
Carbonate 500 milligrams (mg) by mouth (po)
daily, Vitamin D3 1000 units po daily, Folic Acid 1
mg po daily, and Multivitamin with minerals 1 po
daily and regular diet. The admission MDS dated
12/18/12, and the 14 day MDS dated 12/25/12
documented, "K0300. Weight Loss Loss of 5% or
more in the last month or loss of 10% or more in
last 6 months 1. Yes, on physician - prescribed
weight-loss regimen..."

During an interview in the conference room on
5/22/13 at 11:55 AM, the Registered Dietitian
F 278  Continued From page 5

stated, "Admission note documented edema on admission. Nurse document the weights. I usually look at the weights over a 30/60/90/day... She [Resident #167] was on Lasix, so she had a physician’s order for weight loss. "No order found for Lasix." She didn’t have a order then... In February she got med pass supplement and in March she had a 2 pound weight gain. She was admitted 12/19/12 with edema probably came from nursing admission assessment. Yes, on 12/12/12 the nurse documented 2T [plus] edema to right lower extremity. Med pass supplements are documented in my notes... If a resident is on Lasix for edema I mark yes on a planned weight loss program, this is MDS instruction on the help screen."

During an interview in the conference room on 5/22/13 at 11:55 AM the Director of Nursing (DON) stated, "We don’t document med pass, doesn’t require an order, we only document prescribed supplements. Nurses are required to notify the MD of weight loss. The MD is notified by fax by the nurses. There is a purple sheet on the MARS, this alerts nurses to give with med pass, they are suppose to give with med pass documentation is not the MARS, we don’t document RD [Registered Dietitian] recommendations we only document MD prescribed supplements... the MDS is based on entire medical record, Section K of MDS [named RD] does that part."

The MDS dated 12/18/12 and 12/25/12 inaccurately documented the resident was on a physician’s prescribed weight loss regimen order.

<table>
<thead>
<tr>
<th>F 315</th>
<th>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</th>
<th>F 315</th>
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| Event ID: H1TY11 | Facility ID: TN2707 | If continuation sheet Page 6 of 11 |
F 315 Continued From page 6

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review, and interview, it was determined the facility failed to ensure strict intake and output was documented for 1 of 2 (Resident #13) sampled residents of the 2 residents include in the stage 2 review with Foley catheters.

The findings included:

Review of the facility's "DOCUMENTATION GUIDELINES" policy documented, "...Intake and Output Records are used when requested by a physician;... records include... Total fluid intake in ml's [milliliters]... total fluid output in ml's... Correct addition of total fluids for 24 hours..."

Medical record review for Resident #13 documented an admission date of 1/7/13 with diagnoses of Chronic Venous Stasis, Bilateral Chronic Lower Extremity Cellulitis, Bilateral Leg Edema, Osteoarthritis, Gastroesophageal Reflux, Hypertension, Hyperlipidemia, Anxiety, Morbid Obesity, Congestive Heart Failure and

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 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.

Complete review of medical record for resident #13 on 5/23/13 by DON with updated orders to reflect the current status of the resident.

All residents with Foley catheters were reviewed by DON 5/23/13 for accurate documentation for justification of Foley catheter.

Licensed nurses inserviced by DON 6/3/13 and 6/4/13 to ensure accurate documentation is documented for justification of Foley catheter.

DON, ADON, or restorative nurse will begin QA process week of 6/10/13 and will QA identified residents for accurate documentation for justification of Foley catheter.

QA process will continue weekly x 4, then report to QA committee. If standards are not met, follow-up will be completed until all criteria is acceptable.
Continued From page 7

Vancomycin Resistant Enterococcus in Urine.

During an interview in the conference room on 5/22/13 at 2:25 PM, the Director of Nursing (DON) was asked why Resident #13 had a Foley catheter. The DON stated, "...Strict I and O... monitoring intake and output to record what she is taking in and putting out..." The DON was asked where the intake and output was documented. The DON stated, "The intake and output sheet..." The DON confirmed that Resident #13's intake was not documented as ordered by the physician.

Based on a 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.

Registered Dietitian was counseled 6/3/13 by Administrator on ensuring each resident receives nutritional interventions to maintain acceptable nutritional status to maintain and prevent weight loss.

F 315
F 325
F 325  Continued From page 8
This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review and interview, it was determined the facility failed to ensure each resident received nutritional interventions to maintain acceptable nutritional status to maintain and prevent weight loss for 1 of 3 (Resident #167) sampled residents reviewed of the 15 residents with nutritional concerns.

The findings included:

Review of the facility's "Clinical Resource/Best Practice Guidelines for Dietary Services" policy documented, "...A high calorie, high protein commercial supplement will be given during medication pass..."* 

Review of the facility's "MED PASS SUPPLEMENT PROCEDURE FOR PLACING PATIENT" policy documented, "...PURPOSE: To assure patients receive Med Pass Supplement when nutritional status warrants... MED NURSE... Give med pass supplement..."

Review of the facility's "UNPLANNED WEIGHT LOSS" policy documented, "...Implement interventions and evaluate outcomes... Revise goals and approaches as needed..."

Medical record review for Resident #167 documented an admission date of 12/11/12 and discharge date of 3/21/13 with diagnoses of Status Post (S/P) Right Hip Fracture and Repair, Difficulty Walking, History of Falls, History of Breast Cancer, Osteoarthritis, Peripheral Neuropathy, Hyperlipidemia, Communication Deficit, Lack of Coordination, History of Right

Completed review of the medical record for resident #167 was completed 6/4/13 by Registered Dietitian.

DON and Registered Dietitian were inserviced by Administrator 6/4/13 regarding systemic approach of ensuring each resident receives nutritional interventions to maintain acceptable nutritional status and prevent weight loss and to ensure interventions are documented in the resident's medical record.

Effective 6/10/13 Registered Dietitian will document and evaluate nutritional interventions of patients with significant weight loss to maintain acceptable nutritional status and to prevent further weight loss.

Registered Dietitian will begin QA process week of 6/10/13 and will review the medical record of residents with significant weight loss for documentation and evaluation of nutritional interventions.

QA process will continue weekly x 4, then report to QA committee. If standards are not met, follow-up will be completed until all criteria are acceptable.
Mastectomy, Gastro Esophageal Reflux Disease, Anemia, and Arrhythmia. Review of the comprehensive care plan with an admission date of 12/11/12 and updated 3/12/13 documented, "...BMI [Body Mass Index] < [less than] accepted limits with potential for further weight loss if [related to] intake < 75% [percent] at most meals... Provide med pass supplement with each med pass." Review of a dietary note dated 12/18/12 documented, "...Weight records indicate 7# [pound] (5.9%) weight loss since admission... Mini Nutrition Assessment (MNA) completed with a score indicating malnutrition... Recommend: med pass supplement with each med pass for additional calories [calories] and protein." A dietary note dated 1/8/13 documented, "...Weight records indicate pt has lost 12# (9.7%) since admission... Mini Nutrition Assessment score indicates malnutrition... pt [patient] reports that she had not tried the med pass supplement yet." The "Weight Record" for Resident #167 documented, Review of Resident #167's weight records documented, 12/11/12 - 119#, 12/18/12 - 112#, 12/25/12 - 109.8#, 1/18/13 - 105.8# and 1/18/13 - 107.4#. The facility was unable to provide documentation that the Med Pass supplement was given during the month of December 2012.

During an interview in the conference room on 5/22/13 at 11:55 AM, the Registered Dietician (RD) stated, "I document in my notes if a resident gets supplements... nurses notify the doctor of weight loss... I go over the 30, 60 and 90 days weights... she [Resident #167] got med pass supplement... Med pass supplements are documented in my notes... The nurses document in the MAR [Medication Administration Record] if they have a med pass supplement."
F 325  Continued From page 10

During an interview in the conference room on 5/22/13 at 11:58 AM, the Director of Nursing (DON) was asked for documentation of the med pass supplement provided for Resident #167. The DON stated, "...We don't document med pass... doesn't require an order... we only document prescribed supplements... There is a purple sheet on the MARs... this alerts nurses to give with med pass... they are suppose to give with med pass... documentation is not on the MARs... we don't document RD recommendations we only document MD prescribed supplements..."

During an interview in the conference room on 5/23/13 at 8:40 AM, the DON was asked to provide the "House Med. Pass, Meal %, BM [bowel movement] Tracking Sheet" for December 2012 that documented the Med Pass supplement was administered to Resident #167. The DON stated, "We destroy them after 6 months... don't have December [2012]..." The DON was asked if there is a policy or procedure for weight loss. The DON stated, "There isn't a written policy... There is a procedure... The Restorative Team weighs the resident... If a discrepancy is found the team notifies the nurse... nurse verifies discrepancy... discrepancy referred to Dietician... Dietician works from that form..."