STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:

445232

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

09/11/2013

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

PINE MEADOWS HEALTH CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

700 NUCKOLLS ROAD

BOLIVAR, TN 38008

(X4) ID PREFIX TAG

F 159

SS=E

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

F 159

483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS

Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.

The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the

Residents #30, 71, 82, 94, and 142 have been informed of the availability of their personal funds from their accounts at any time if they have money available in the account.

Current residents who have funds in the Patient trust fund were informed of availability of their personal funds any time they request funds if they have money available in their account.

The availability of funds (as applicable) will be reviewed in the next Resident Council meeting which is scheduled for Tuesday September 24th.

The Administrator will notify residents in writing who have funds in the Patient Trust Fund that funds are available to each resident any time they request funds from their account (as applicable).

The facility will continue to have funds available after hours at the A and B Nurses Station with the RN Charge Nurse. These funds will be reconciled daily by the Receptionist. A daily trial

LAbORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Hinda Mccartney

ADMIN

TITLE

9/24/2013

DATE

SEP 26, 2013

RECEIVED

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.
<table>
<thead>
<tr>
<th>ID</th>
<th>PRE/CA</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LGC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 159</td>
<td></td>
<td></td>
<td>Continued From page 1</td>
<td>F 159</td>
<td></td>
<td></td>
<td>balance will continue to be produced after the reconciliation so that whoever is issuing the money to the Resident will be aware of availability of funds. The Charge Nurse will have a receipt of funds given signed by the Resident.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SSI resource limit for one person, specified in section 1511(e)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</td>
<td></td>
<td></td>
<td></td>
<td>The Administrator/Designee will audit that funds are available after hours and that reconciliation is completed and receipts issued to applicable residents. The audits will be completed 3 times weekly for 2 weeks, weekly for 2 weeks, weekly for 4 weeks and then monthly.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>This REQUIREMENT is not met as evidenced by:</td>
<td></td>
<td></td>
<td></td>
<td>Audit results will be reviewed monthly in the QA&amp;A meeting with changes to the plan as deemed appropriate by the QA&amp;A Committee.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Based on interview, it was determined the facility failed to ensure residents had access to petty cash on an ongoing basis for 5 of 12 (Residents #30, 71, 82, 94 and 142) sampled residents interviewed with a personal funds account of the 37 residents included in the stage 2 review.</td>
<td></td>
<td></td>
<td></td>
<td>9/28/2013</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>ID/Prefix/Tag</td>
<td>Provider ID</td>
<td>Address/State/Zip</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>---------------</td>
<td>-------------</td>
<td>--------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>09/11/2013</td>
<td></td>
<td>445232</td>
<td>700 NUCKOLLS ROAD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BOLIVAR, TN 38008</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**F 159 Continued From page 2**

5. During an interview in Resident #142's room on 9/9/13 at 3:21 PM, Resident #142 was asked if she could get money from her account anytime she wanted. Resident #142 stated, "No."

6. During an interview in the business office on 9/11/13 at 1:00 PM, the receptionist was asked if residents could get their money anytime they wanted. The receptionist stated, "I'm here from 8 [AM] till [until] 5 [PM]." The receptionist was then asked if residents could get their money once she's gone. The receptionist stated, "They [residents] don't." The receptionist verified funds are not available for residents after 5 PM.

<table>
<thead>
<tr>
<th>Date</th>
<th>ID/Prefix/Tag</th>
<th>Provider ID</th>
<th>Address/State/Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/11/2013</td>
<td></td>
<td>445232</td>
<td>700 NUCKOLLS ROAD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BOLIVAR, TN 38008</td>
</tr>
</tbody>
</table>

**F 279 SS-D 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 §483.25; 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).

The care plan of Resident #5 has been updated to include ROM exercises to the left lower extremity.

Current residents have had their MDS assessments and care plans reviewed to validate whether range of motion (ROM) should be care planned. As applicable, care plans have been completed.

The MDS Coordinators and interdisciplinary team (IDT) were re-educated by 9/25/13 regarding using the results of the MDS assessment to develop, review and revise the resident's comprehensive care plan.
F 279 Continued From page 3

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation and interview, it was determined the facility failed to have a care plan for range of motion (ROM) for 1 of 18 (Resident #5) sampled residents reviewed of the 37 residents included in the stage 2 review.

The findings included:

Medical record review for Resident #5 documented an admission date of 10/21/11 with diagnoses of Osteoarthritis of Pelvis and Lower Leg, Difficulty Walking, Muscle Weakness, History of Falls, Abdominal Aneurysm, Anemia, Urinary Tract Infection, Hypertension, Coronary Artery Disease, Degenerative Joint Disease, Neurogenic Bladder, Hypokalemia and Anxiety. Review of the "ROM / CONTRACTURE REVIEW" dated 7/7/13 documented, "...Knee L [left] 2 [indicating moderate limited ROM]... intervention assistance required. (for anatomical site scores of 1 or 2) [yes]..." Review of the quarterly Minimum Data Set (MDS) assessment with an assessment reference date of 6/13/13 documented a functional limitation in ROM on both sides for lower extremities. Review of the care plan conference summary dated 6/20/13 documented, "...CARE PLAN ELEMENT... Risks/Consequences... Contractures decline in LOF [level of functioning]..." Review of the care plan dated 2/14/13 and updated 6/20/13 did not include care for ROM.

Observations in Resident #5's room on 9/9/13 at 12:15 PM and on 9/10/13 at 12:30 PM, revealed Resident #5 seated on the side of the bed, left leg appeared slightly contracted.

The MDS nurses and IDT will review the MDS and care plans during the IDT care conference meeting to determine if the assessment results indicate the need for development or revision of the comprehensive care plan. The MDS Nurses will audit twice weekly for 2 weeks, then weekly for 2 weeks and then monthly.

Audit results will be reviewed in the monthly QA&A meeting with revision to the plan as deemed appropriate by the QA&A Committee 9/28/2013.
Observations in Resident #5's room on 9/9/13 at 3:15 PM, on 9/10/13 at 7:50 AM, and on 9/10/13 at 3:30 PM, revealed Resident #5 lying in the bed, left leg appeared slightly contracted.

During an interview at the CD nurses' station on 9/9/13 at 4:15 AM, Nurse #1 was asked if Resident #5 had a contracture. Nurse #5 stated, "Yes, her left leg."

During an interview in the MDS office on 9/11/13 at 11:10 AM, the MDS Coordinator was asked if Resident #5 had a care plan addressing ROM. The MDS Coordinator stated, "The resident is not contracted. She is at risk due to she keeps her leg in the same position due to pain and this puts her at risk for contractures." The MDS Coordinator confirmed there was no care plan for ROM. The MDS Coordinator stated, "I don't see it on there [ROM on the resident's care plan]."