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<th>PROVIDER PLAN OF CORRECTION</th>
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| F 276 | SS=D | **F 276** This Plan of Correction is submitted as required under State and Federal Law. The submission of this plan does not constitute an admission on the part of Pleasant View Health Care Center ("Facility") as to accuracy of the findings nor does it constitute any of the deficiencies cited as correctly applied. Any changes to Pleasant View Health Care Center Policies and Procedures should be considered to be subsequent remedial measures as that concept is employed in the Rule 407 of the Federal Rules of Evidence and any corresponding State Rule of any proceeding on that basis. The Facility submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the facility or any employee, agent, officer, director or shareholder of the Facility. 

No ill effects were noted as a result of this deficient practice. All residents have the potential to be affected by this deficient practice. On 7/16/10 facility Director of Nursing (DON) in-serviced the facility's MDS Coordinator regarding timely completion of MDS Assessments. The facility's DON or designee will review the facility MDS submission report weekly for the next 90 days, comparing it to the facility MDS calendar, then randomly thereafter, to

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| F 276.30(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS     | F 276 | This Plan of Correction is submitted as required under State and Federal Law. The submission of this plan does not constitute an admission on the part of Pleasant View Health Care Center ("Facility") as to accuracy of the findings nor does it constitute any of the deficiencies cited as correctly applied. Any changes to Pleasant View Health Care Center Policies and Procedures should be considered to be subsequent remedial measures as that concept is employed in the Rule 407 of the Federal Rules of Evidence and any corresponding State Rule of any proceeding on that basis. The Facility submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the facility or any employee, agent, officer, director or shareholder of the Facility. 

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PLEASANT VIEW HEALTH CARE CENTER

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| F278 | Continued From page 1
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 interviews, it was determined the facility failed to ensure each resident received an accurate assessment of behaviors for 1 of 15 (Resident #13) sampled residents.

The findings included:
Medical record record for Resident #13 documented an admission date of 1/29/09 with diagnoses of Congestive Heart Failure, Irritable

| F-278 | Ensure that this requirement is met. All findings will then be reported to the facility's Quality Assurance (QA) committee for review and further recommendations. The QA committee consists of the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Dietary Manager, Social Services Director and Activities Director.

F278

No ill effects were noted as a result of this deficient practice. All residents have the potential to be affected by this deficient practice. On 7/20/10 the facility's DON in-serviced the facility's MDS Coordinator on accuracy of MDS Assessments. The facility DON or designee will review all MDS assessments completed for the next 4 weeks then randomly thereafter, to ensure that this requirement is met. All findings will then be reported to the facility's Quality Assurance (QA) committee for review and further recommendations. The QA committee consists of the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Dietary Manager, Social Services Director and Activities Director.
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<th>COMPLETION DATE</th>
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</table>
| F 278         | Continued From page 2 Bowel Syndrome, Hypertension, Cellulitis, Peripheral Vascular Disease, Diabetes Mellitus, Depression, Insomnia and Dementia. Review of the care plan dated 2/11/10 documented behavior of physical/verbal aggression related to anger/anxiety as evidenced by scratching, hitting, pinching, grabbing at others yelling, cursing, and verbal threats. Review of the Minimum Data Set (MDS) assessment dated 2/11/10 and quarterly assessment dated 5/1/10 did not reflect an assessment of the behavioral symptoms. During an interview outside room 33 on 7/8/10 at 10:25 AM, Certified Nursing Assistance #2 stated, "He [Resident #13] refuses care a lot, he sometimes will hit me when I'm trying to take care of him. Sometimes he won't let me do anything for him, I try again later."
|               | F 278                                                                                           |               |                                                                                                | 8/18/10         |
| F 280 SS=E    | 483.20(d)(3), 483.10(k)(2) RIGHT TO 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. No ill effects were noted from this deficient practice. All residents have the potential to be affected by this deficient practice. On 7/21/10 the facility DON in-serviced the facility's MDS Coordinator on developing a comprehensive care plan and updating | F280           |
### F 280 Continued From page 3

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observations and interviews, it was determined the facility failed to revise the comprehensive plan of care to address cognition, decision making, incontinence, range of motion, hearing impairment, falls and/or hospice care for 5 of 15 (Residents #1, 3, 5, 6 and 11) sampled residents.

The findings included:

1. Medical record review for Resident #1 documented an admission date of 8/21/09 with diagnoses of Hypertension, Sepsis, Dehydration, Urinary Tract Infection, Diabetes Mellitus, Anxiety, Prostate Cancer and Cerebral Vascular Accident. Review of the Minimum Data Set (MDS) dated 9/3/09 and the quarterly assessment dated 6/7/10 documented Resident #1 had limited range of motion (ROM) and incontinence of bowel. Review of Resident #1's care plan dated 9/3/09
Continued from page 4
and updated 6/7/10 revealed no documentation to address the limited ROM and the incontinence of the bowel.

During an interview in the conference room on 7/8/10 at 1:50 PM, Nurse #8 stated, "It's [incontinent care and ROM] not there. I need to add those [incontinent and ROM] to the care plan."

2. Medical record review for Resident #3 documented an admission date of 9/14/02 with diagnoses of Dysphagia, Cerebrovascular Disease, Congestive Heart Failure, Diabetes Mellitus, Hypertension, Osteoporosis, Hypothyroidism and Neuropathy. Review of the MDS dated 12/15/09 documented Resident #3's hearing pattern was assessed to hear in special situations only—speaker has to adjust tonal quality and speak distinctly and the resident's vision patterns was assessed as moderately impaired—limited vision; not able to see newspaper headlines, but can identify objects. Review of Resident #3's care plan updated on 6/23/10 documented vision impairment, glasses when reading. The care plan did not address the resident's hearing impairment.

Review of the Social Progress Notes dated 6/15/10 documented, "Her [Resident #3] vision is poor and she has to use a magnifying glass to read her big print books, hearing is poor in her right and left ear, but adequate c [with] a hearing aide and you have to talk to her real loud for her to hear what you are saying..."

Observation in Resident #3's room on 7/7/10 at 9:45 AM revealed a magnifying glass on Resident #3's over bed table.
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<td>F 280</td>
<td>Continued From page 5</td>
<td>During an interview in Resident #3's room on 7/7/10 at 11:25 AM, Resident #3 stated she uses a magnifying glass to read, does not wear glasses, does not wear a hearing aide and refuses one. During an interview in the Social Services office on 7/7/10 at 2:45 PM, the Social Service Director stated, &quot;Her [Resident #3] vision is bad. She uses magnifying glass and large print books. She doesn't wear glasses. She keeps her TV [television] really loud because her hearing is bad.&quot;</td>
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<td>F 280</td>
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<td>3. Medical record review for Resident #5 documented an admission date of 5/1/09 with diagnoses of Diabetes Mellitus, Herpes Zoster, Bipolar, Hypertension, Vertigo, Hyperlipidemia and Constipation. Review of the MDS dated 5/14/10 documented Resident #5 had impaired memory and decision making ability and incontinence of bowel and bladder. Review of Resident #5's care plan dated 6/14/10 revealed no documentation to address Resident #5's impaired memory and decision making ability and the incontinence of bowel and bladder. During an interview in the conference room on 7/8/10 at 1:45 PM, Nurse #8 stated, &quot;It's [care plan for incontinent, cognitive and decision making] not here, must have overlooked it.&quot;</td>
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| | | 4. Medical record review for Resident #6 documented an admission date of 6/9/04 with diagnoses of Anxiety, Agitation, Hypertension, Cerebral Vascular Disease, Chronic Obstructive Pulmonary Disease, Depressive Disorder, Hemiplegia and Low Back Pain. Review of the
F 280  Continued From page 6

MDS dated 3/30/10 and the quarterly assessment dated 6/17/10 documented Resident #8 was assessed to have short and long term memory problem and some difficulty in new situations only for cognitive skills for daily decision making. Review of the Nurse's Notes dated 5/23/10 at 9:30 PM documented Resident #8 was found sitting on the floor in front of a wheelchair and stated he wanted to get up out of chair. Review of the care plan updated on 5/23/10 documented Resident #8 was instructed on getting assistance with getting out of chair. The Nurse's Notes dated 6/6/10 at 9:30 PM documented Resident #8 was found lying on floor beside wheelchair. Review of the care plan updated 6/6/10 documented the resident was educated to call for assist with transfers. The Nurse's Notes dated 7/1/10 at 8:30 PM documented the resident was found lying on floor in bathroom and stated he slipped while trying to use the bathroom. Review of the care plan updated 7/1/10 did not document any interventions to prevent falls.

During an interview in the conference room on 7/8/10 at 8:40 AM, the Director of Nursing (DON) was asked if instructing a resident to ask for assistance is an appropriate intervention for a resident that has short and long term memory problems. The DON stated, "If they have memory problems, then this is not appropriate. This is why we have our meetings to review falls and if the interventions are appropriate."

5. Medical record review for Resident #11 documented an admission date of 10/1/07 with diagnoses Diabetes Mellitus, Hypothyroidism, Schizophrenia, Anxiety, Hypertension, Dementia with Delusions and Depression. Resident #11 was readmitted to the facility on 6/24/10 after
| F 280 | Continued From page 7 hospitalization with a diagnosis of terminal Chronic Obstructive Pulmonary Disease. Review of the hospital transfer order form dated 6/24/10 documented to admit to nursing home for hospice residential care with comfort measure only. Review of the resident's care plan revealed no documentation the resident was receiving hospice care. During an interview in the MDS office on 7/8/10 at 11:20 AM, Nurse #3 stated, "The admitting nurse should put care plan in chart, if not, then I am the catch up person. I will get one on there.

F 309 | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review and interviews, it was determined the facility failed to provide necessary care and services according to physician's orders for sliding scale insulin, pre and post dialysis weights and/or to obtain a physician's order for hospice care for 3 of 15 (Residents #5, 10 and 11) sampled residents.

The findings included:
1. Review of the facility's guidelines for following sliding scale insulin coverage documented,
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<td>F 309</td>
<td>Continued From page 8</td>
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<td>findings will then be reported to the facility's Quality Assurance (QA) committee for review and further recommendations. The QA committee consists of the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Dietary Manager, Social Services Director and Activities Director.</td>
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"...READ THE MD [Medical Doctor] ORDER ON THE DIABETIC FLOW RECORD IN IT'S ENTIRETY [ENTIRETY]...FOLLOW EACH OF OUR FACILITY MD SLIDING COVERAGE ORDERS...GIVE THE AMOUNT OF INSULIN REQUIRED ACCORDING TO THE MD ORDER, AND INITIAL AS GIVEN..."

Medical record review for Resident #5 documented an admission date of 5/1/09 and a readmission date of 11/11/09 with diagnoses of Acute Encephalopathy, Bipolar, Hypertension and Diabetes Mellitus. Review of a physician's order dated 1/5/10 and updated 6/7/10 documented, "...NOVOLIN R [Regular] 100U/ML [units per milliliter] VIÁL SSI [sliding scale insulin]: "121- [to] 200= [amount of insulin to administer] 2U..."

Review of the January 2010 diabetic record documented the following:
- a. 1/4/10-6AM-Blood Sugar (BS) = 121, insulin given =0, correct dose = 2 units.

Review of the February 2010 diabetic record documented the following:
- a. 2/21/10-4PM-BS = 148, insulin given = 0, correct dose = 2 units.
- b. 2/21/10-8PM-BS = 135, insulin given = 0, correct dose = 2 units.
- c. 2/24/10-4PM-BS = 123, insulin given = 0, correct dose = 2 units.

Review of the March 2010 diabetic record documented the following:
- a. 3/14/10-8PM-BS = 127, insulin given = 0, correct dose = 2 units.
- b. 3/15/10-8PM-BS = 124, insulin given = 0, correct dose = 2 units.
### Continued From page 9

Review of the April 2010 diabetic record documented the following:

- a. 4/15/10-6AM-BS=122, insulin given=0, correct dose=2 units.
- b. 4/19/10-8PM-BS=121, insulin given =0, correct dose =2 units.
- c. 4/26/10-4PM-BS=134, insulin given =0, correct dose = 2 units.
- d. 4/29/10-11AM-BS=121, insulin given =0, correct dose =2 units.

Review of the May 2010 diabetic record documented the following:

- a. 5/5/10-4PM-BS=125, insulin given =0, correct dose=2 units.
- b. 5/8/10-6AM-BS=124, insulin given= 0, correct, dose=2 units.
- c. 5/13/10-4PM-BS=124, insulin given =0, correct dose=2 units.
- d. 5/17/10-8PM-BS=142, insulin given =0, correct dose=2 units.
- e. 5/22/10-6AM-BS=125, insulin given =0, correct dose = 2 units.
- f. 5/30/10-8PM-BS=121, insulin given =0, correct dose = 2 units.

During an interview in the conference room on 7/8/10 at 2:25 PM, the Director of Nursing (DON) confirmed that insulin was not given when it should have been given. The DON stated, "I can show you the incident report for the medications errors that I filled out. I laminated it on the MAR [Medication Administration Record] and I told them [referring to nurses] they have to read the entire order and not go by memory."

2. Medical record review for Resident #10 documented an admission date of 5/6/10 with diagnoses of End Stage Renal Disease,
Peripheral Artery Disease and Bradycardia. Review of a physician’s order dated 7/2/10 documented, "Dialysis 3 times week, Tue [Tuesday], Thur [Thursday] and Sat [Saturday]." Review of the comprehensive care plan dated 5/13/10 documented, "Problem/Need: ELDER AT RISK FOR COMPLICATIONS RELATED TO HEMODIALYSIS THAT INCLUDE: ...WEIGHT FLUCTUATIONS ...Approaches ...PRE/POST WEIGHTS AS PER DIALYSIS." The facility was unable to provide documentation of the pre/post weights being done for the month of June 2010.

During an interview in the conference room on 7/8/10 at 11:05 AM, Nurse #5 stated, "I don't have them [referring to the pre/post weights]. I have looked everywhere."

During an interview in the conference room on 7/8/10 at 1:55 PM, Nurse #5 stated, The pre and post weights are per us and dialysis. [Residents] Should be weighed before they go to dialysis and when they return.

During an interview in the conference room on 7/8/10 at 2:35 PM, the DON stated, "We had the weights for May [2010], but didn't get pulled over to June [2010] when they did the orders. I've got them doing it right now as he just got back from dialysis."

3. Medical record review for Resident #11 documented an admission date of 10/1/07 with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Hypothyroidism, Hyperlipidemia, Schizophrenia, Anxiety, Arthropathy, Hypertension, Dementia, and Depression. Review of the Physician's transfer orders from the hospital dated 6/24/10.
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<td>F 309</td>
<td>Continued From page 11 documented, &quot;Admit to [named nursing home] for Hospice residential care... Terminal Dx (diagnosis): COPD...&quot; Review of the current Physician's recertification orders dated 7/2/10 did not include an order for hospice care. During an interview in front of the accounts receivable office on 7/8/10 at 11:30 AM, Nurse #7 stated, &quot;The nurses must have failed to get the order when she was admitted to hospice, I will get an order now.&quot;</td>
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<td>F 315</td>
<td>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on review of &quot;Tennessee CNA [Certified Nursing Assistant] Candidate Handbook, Version 4.5, Oct [October] 1, 2009, medical record review, observations, and interview, it was determined the facility failed to ensure that correct pericare was performed according to training and standards for nurse aides for 1 of 2 (Resident #4) sampled residents observed receiving catheter care. The findings included:</td>
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<tr>
<td>F 315</td>
<td>F315 No ill effects were noted as a result of this deficient practice. All residents have the potential to be affected by this deficient practice. On 7/14/10 North Side Clinical Advocate conducted a one on one in-service with C.N.A. #1 regarding proper pericare procedure. On 7/9/10, 7/10/10, 7/12/10, 7/14/10, 7/15/10, 7/20/10, and 7/21/10 facility's North Side Clinical Advocate in-serviced C.N.A.'s regarding proper pericare procedure. The facility Clinical Advocates will conduct skill tests observation for all C.N.A.'s to be completed by 7/29/10. The facility's North Side Clinical Advocate or designee will continue to perform skills test observations randomly to ensure that this requirement is met. All findings will then be reported to the facility's Quality Assurance (QA) committee for review and further recommendations. The QA committee consists of the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Dietary Manager, Social Services Director and Activities Director.</td>
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**Summary Statement of Deficiencies**

Each deficiency must be preceded by full regulatory or LSC identifying information.

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<tr>
<th>ID</th>
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<th>Provider's Plan of Correction</th>
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<td>F 315</td>
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Review of "CNA Candidate Handbook" Version 4.5 Oct 1, 2009, documented "...clean one side... from top to bottom using a clean portion of a washcloth with each stroke... Rinses and pats dry the area from top to bottom..."

Medical record review for Resident #4 documented an admission date of 5/19/08 and a readmission date of 2/2/10 with diagnoses of Cerebral Vascular Accident with Hemiparesis, Renal Insufficiency, Dysphagia, Dilantin Toxicity, Diabetes Mellitus, Anemia, Seizures, Anxiety, Hypertension, and Coumadin Toxicity.

Observations in Resident #4's room on 7/7/10 at 2:55 PM revealed CNA #1 performed pericare on Resident #4. Resident #4 was positioned on his back. After washing the penis, CNA #1 took a clean washcloth folded it, sprayed it with no rinse pericare. CNA #1 washed the left side of the scrotum from the back to the front, folded the washcloth, washed the right side of the scrotum from back to front. CNA #1 completely unfolded the washcloth, refolded and rewashed the right side of the scrotum in a back to front motion. CNA #1 took another washcloth, wet it with spray, folded it and washed the right groin area from the back to the front, folded the washcloth and washed the right groin area again from the back to front; folded another washcloth, wet the wash cloth with spray and washed the left groin from back to front. CNA #1 folded the cloth and again washed the left groin from back to front.

During an interview in Resident #4's room on 7/7/10 at 3:30 PM CNA #1 stated, "Oh; I realize what I should have done [wash front to back not back to front]."
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<th>F323</th>
<th>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</th>
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<td>SS=D</td>
<td>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</td>
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This **REQUIREMENT** is not met as evidenced by:

- Based on medical record review, review of an incident report and interview, it was determined the facility failed to do a thorough investigation of an incident and/or did not provide appropriate interventions on the care plan for falls for 2 of 6 (Residents #4 and #6) sampled residents with falls.

The findings included:

1. Medical record review for Resident #4 documented an admission date of 5/19/08 and a readmission date of 2/2/10 with diagnoses of Cerebral Vascular Accident with Hemiparesis, Renal Insufficiency, Dysphagia, Diltiazem Toxicity, Diabetes Mellitus, Anemia, Seizures, Anxiety, Hypertension, and Coumadin Toxicity.

Review of an incident report dated 12/18/09 documented Resident #4 was found on the floor. Intervention was to not pull himself too close to the side rails.

During an interview in the conference room on 7/9/10 at 7:40 AM, the Director of Nursing (DON) stated, "Did not do a thorough investigation as there was no injury. The person did the report"
<table>
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<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F323</td>
<td>Continued From page 14 assumes that was what happened.</td>
<td>F323</td>
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</tbody>
</table>

2. Medical record review for Resident #6 documented an admission date of 6/9/04 with diagnoses of Anxiety, Agitation, Hypertension, Cerebral Vascular Disease, Chronic Obstructive Pulmonary Disease, Depressive Disorder, Hemiplegia and Low Back Pain. Review of the MDS (Minimum Data Set) dated 3/30/10 and the quarterly assessment dated 8/17/10 documented Resident #6 was assessed to have short and long term memory problem and some difficulty in new situations only for cognitive skills for daily decision making. Review of the Nurse's Notes dated 5/23/10 at 9:30 PM documented the resident was found sitting on the floor in front of the wheelchair and stated he wanted to get up out of chair. Review of the care plan updated on 5/23/10 documented the resident was instructed on getting assistance getting out of chair.

Review of the Nurse's Notes dated 6/6/10 at 9:30 PM documented the resident was found found lying on the floor beside wheelchair. Review of the care plan updated 6/6/10 documented the resident was educated to call for assist with transfers.

Review of the Nurse's Notes dated 7/1/10 at 8:30 PM documented the resident was found lying on floor in bathroom and stated he slipped while trying to use the bathroom. Review of the care plan updated 7/1/10 did not document any interventions to prevent falls.

During an interview in the conference room on 7/8/10 at 8:40 AM, the DON was asked if instructing a resident to ask for assistance is an appropriate intervention for a resident that has
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<tr>
<td>F 323</td>
<td>Continued From page 15 short and long term memory problems. The DON stated, &quot;If they have memory problems, then this is not appropriate. This is why we have our meetings to review falls and if the interventions are appropriate.&quot;</td>
</tr>
<tr>
<td>F 332</td>
<td>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</td>
</tr>
<tr>
<td>SS=E</td>
<td>The facility must ensure that it is free of medication error rates of five percent or greater.</td>
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</tbody>
</table>

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review, observations and interviews, it was determined the facility failed to ensure 2 of 4 (Nurses #2 and 4) nurses administered medications without a medication error rate of less than 5 percent (%).
A total of 6 medication errors were observed out of 40 opportunities for error, resulting in a medication error rate of 15%.

The findings included:
1. Review of the facility’s "Administering Medications" policy documented, "...Medications must be administered in a safe and timely manner, and as prescribed... 3. Medications must be administered in accordance with the orders, including any required time frame... 6. The individual administering the medications must check the label THREE (3) times to verify the right medication, right dosage, right time and right method of administration before giving the medication... 8. Medications ...must be administered within one (1) hour of their prescribed time, unless otherwise specified (for

No ill effects were noted as a result of this deficient practice. Medication error report was completed for Random Resident #1 on 7/20/10, and Random Resident #1 Family and MD were notified on 7/20/10. Medication error report was completed for Random Resident #2 on 7/21/10, and Random Resident #2 Family and MD were notified on 7/21/10. All residents have the potential to be affected by this deficient practice. On 7/20/10 facility’s DON conducted one on one in-service with nurse #2 regarding facility’s Administering Medication Policy. On 7/21/10 facility’s DON conducted one on one in-service with Nurse #4 regarding facility’s Administering Medication Policy.
On 7/21/10 Licensed Nursing staff was in-service regarding the facility’s Administering Medication Policy. The facility’s DON or Designee will conduct weekly Audits of Medication Pass for the next 4 weeks and randomly thereafter to ensure this requirement is met. All findings will then be reported to the facility’s Quality Assurance (QA) committee for review and further recommendations. The QA committee consists of the Administrator, Director of...
F 332 Continued From page 18 example, before and after meal orders)..."

2. Medical record review for Random Resident (RR) #1 documented an admission date of 8/14/08 with diagnoses of Depression, Seizures, Mental Retardation, Bladder Spasm and Failure to Thrive. Review of a physician's order dated 7/2/10 documented, "...DITROPAN 5MG [milligrams] TABLET TAKE 1 TABLET BY MOUTH 2 TIMES DAILY- 8:30AM and 5:30PM, KEPPRA 500MG TABLET TAKE 1 TABLET BY MOUTH 2 TIMES DAILY- 8:30AM and 5:30PM, RISPERDAL 0.5MG TABLET TAKE 1 TABLET BY MOUTH 2 TIMES DAILY- 8:30AM and 5:30PM, TRILEPTAL 300MG TABLET TAKE 1 TABLET BY MOUTH 2 TIMES DAILY- 8:30AM and 5:30PM; DILANTIN 100MG CAPSULE TAKE 1 TABLET BY MOUTH 3 TIMES DAILY- 8:30AM, 1:30PM and 5:30PM..."

Observations in RR #1's room on 7/6/10 at 11:15 AM, revealed Nurse #2 administered Ditropan 5mg, Keppra 500mg, Risperdal 0.5mg, Trileptal 300mg and Dilantin 100mg to RR #1. The failure to administer these medications within the one (1) hour time frame of scheduled time resulted in medication errors #1, #2, #3, #4, and #5.

During an interview on the 100 hall on 7/8/10 at 11:10 AM, Nurse #2 stated, "I know I blame it on my watch, my watch was slow had lost time."

3. Medical record review for RR #2 documented an admission date of 7/3/07 with diagnoses of Peripheral Vascular Disease, Hypertension, Hypothyroidism and Schizoaffective Disorder, Bipolar. Review of a physician's order dated 7/2/10 documented, "...GEODON 80MG CAPSULE TAKE 1 CAPSULE MY MOUTH"
continued from page 17

DAILY AT 5PM WITH FOOD...

Observations in RR #2's room on 7/7/10 at 4:03
PM, revealed Nurse #4 administered Geodon
80mg to RR #2. The failure to administer the
medication with food resulted in medication error
#8.

F 371

483.35(i) FOOD PROCURE,
STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or
considered satisfactory by Federal, State or local
authorities; and
(2) Store, prepare, distribute and serve food
under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was
determined the facility failed to ensure that food
was served and stored under sanitary conditions
as evidenced by raw chicken in the sanitize
compartment of the three compartment sink
covered with water with no running water, a mop
and broom stored on the floor, the dietary worker
using bare hands to retrieve a dropped
thermometer in the potatoes on the tray line, not
properly cleaning the thermometer, and not
maintaining hot foods at 135 degrees Fahrenheit
(F) or higher which could affect 49 of 60
residents.

The findings included:

No ill effects were noted as a result of this
deficient practice. All residents have the
potential to be affected by this deficient
practice. On 7/12/10 and 7/21/10 Dietary
Manager in-serviced staff on proper kitchen
sanitation including, proper cleaning and
storage of food, proper cleaning of
equipment, and proper food temperatures.
Dietary Manager or Designee will make
sanitation rounds 5 times a week for the next
7 weeks and randomly thereafter to ensure
this requirement is met. Dietary Manager or
Designee will also randomly check the food
line temperatures 3 times a week for the next
4 weeks and then randomly thereafter to
ensure that this requirement is met. All
findings will then be reported to the
facility's Quality Assurance (QA)
committee for review and further
recommendations. The QA committee
consists of the Administrator, Director of
Nursing, Medical Director, Assistant
Director of Nursing, Dietary Manager,
Social Services Director and Activities
Director.
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE &quot;DEFICIENCY&quot;)</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 371</td>
<td>Continued From page 18 1. Observations in the kitchen on 7/7/10 at 8:35 AM and on 7/7/10 at 8:45 AM, revealed raw chicken covered with water in the sanitize compartment of the three compartment sink with no continuous running water. During an interview in the kitchen on 7/7/10 at 8:45 AM, the Dietary Manager (DM) stated, &quot;We thaw the chicken in the refrigerator, then place in the sink to wash off.&quot; During an interview in the conference room on 7/8/10 at 9:30 AM, the DM stated, &quot;She [dietary cook] had the water running, I am not sure why she turned it off.&quot; 2. Observations in the kitchen on 7/7/10 at 11:00 AM, revealed a mop and broom stored on the floor beside the coffee machine. 3. Observations in the kitchen of the tray line on 7/7/10 beginning at 11:30 AM, revealed dietary cook #1, while obtaining tray line temperatures, dropped the thermometer into the pureed potatoes, reached into the potatoes with her bare hands to retrieve the thermometer, rinsed the thermometer with water, and continued to check tray line temperatures. Dietary cook #1 cleansed the thermometer with an alcohol prep prior to checking the tray line temperatures, then rinsed the thermometer with water after each food item was checked. During an interview in the conference room on 7/8/10 at 8:20 AM, the Administrator stated, &quot;We do not have a policy on cleaning the thermometer, but it should be cleansed with an alcohol prep before using and between each food, that is the standard.&quot;</td>
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During an interview in the conference room on 7/8/10 at 9:30 AM, the DM stated, "I would expect them [dietary workers] to clean the thermometer with an alcohol prep in between each food item."

4. Observations in the kitchen on 7/7/10 beginning at 11:30 AM, revealed the following hot food tray line temperatures:
   a. Pureed tomatoes - 120 degrees F.
   b. Pureed chicken - 110 degrees F.
   c. Fried chicken - 110 degrees F.
   d. Pureed potatoes - 100 degrees F.
   e. Chopped chicken - 130 degrees F.
   The trays continued to be prepared to be served without reheating.

During an interview in the conference room on 7/8/10 at 9:30 AM, the DM stated, "I would expect them [dietary workers] to reheat the food if the temperatures are too low. I asked her [dietary cook] if the temperatures were okay, and she said 'yes'. We did not reheat any trays yesterday."

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
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<tr>
<td>F 431</td>
<td>Continued from page 20, appropriate accessory and cautionary instructions, and the expiration date when applicable.</td>
<td>F 431</td>
<td>to ensure this requirement has been met. All findings will then be reported to the facility's Quality Assurance Committee for review and further recommendations. The QA committee consists of the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Dietary Manager, Social Services Director and Activities Director.</td>
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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 have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 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.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure medications were not stored past their expiration date in 1 of 3 (Medication room) medication storage areas.

The findings included:
Observations in the medication room on 7/8/10 at 9:50 AM, revealed the following medications were stored past their expiration date:
  b. A vial of Novolin 70/30 insulin with an expiration date of June 2010.
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<td>F 431</td>
<td>Continued From page 21</td>
<td>F 431</td>
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<td></td>
<td>c. Five vials of Lorazepam 2 milligrams per milliliter with an expiration dates of May 2010.</td>
<td></td>
<td>During an interview in the medication room on 7/8/10 at 9:50 AM, Nurse #6 verified that the above listed medications were stored past their expiration dates.</td>
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</tbody>
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