F 000 INITIAL COMMENTS

The annual Recertification Survey and investigation of complaint numbers TN-20122, 29087, and 29267 was completed on May 23, 2012. Deficiencies were cited under 42 CFR PART 483.13, Requirements for Long Term Care for complaint # TN-29087.

F 280 SS=I	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.

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, and interview, the facility failed to revise the care plan for one resident (#5) of twenty-four residents reviewed.

Unit manager updated the care plan for Resident #5 on May 26, 2012.

Director of Nursing identified high risk residents using all incident reports from October 2011 to current (May 2012), all have been checked for accuracy and completeness; including care plan on interventions by Director of Nursing.

Unit Managers will ensure that all care plans are updated and added to the care plan book with interventions in place. Unit Managers were educated by Director of Nursing on May 29, 2012 to ensure all incident reports have updated care plans attached, added to care plan book and interventions in place and followed.

Director of Nursing will ensure all incident reports have an attached care plan and will correct immediately if not available. Any issues will be brought before the QA committee.

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 disclosed 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 disclosed 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.
F 260 Continued From page 1
The findings included:

Resident #5 was readmitted to the facility on October 28, 2008, with diagnoses including PEG (Percutaneous Endoscopic Gastrostomy) Tube Placement, Dysphagia (swallowing impairment), I.B.S. (Irritable Bowel Syndrome), Erosive Gastroitis (inflammation of the stomach), Dementia, Alzheimer's Type, Osteoporosis, Glaucoma, Diabetes Mellitus, Type II, Vitamin D Deficiency, and Hypertension (High Blood Pressure).

Medical record review of a Fall Risk Assessment dated November 1, 2011, revealed the resident was at high risk for falls.

Medical record review of an Unusual Occurrences Nurses Progress Note dated November 29, 2011, at 8:00 p.m., revealed "...Resident was receiving shower and slid from shower chair into floor ...Resident was assessed and neuro (neurological) checks started...WNL (Within Normal Limits), resident denies pain or injury ...MD (Medical Doctor) and son ... notified at 8:10 p.m. Will continue to monitor..."

Medical record review of the IDT (Interdisciplinary Team) Plan of Care dated November 8, 2011, and last updated May 8, 2012, revealed the Plan of Care had not been revised to reflect the resident's fall.

Interview with the Minimum Data Set (MDS) Coordinator on May 22, 2012, at 2:55 p.m., at the MDS coordinator's office door, confirmed the fall investigation report revealed a Plan of Care, but the resident's Interdisciplinary Plan of Care was
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 280</td>
<td>Continued From page 2 not revised to reflect the fall or new interventions put in place after the fall.</td>
</tr>
<tr>
<td>F 281</td>
<td>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</td>
</tr>
<tr>
<td>SS=D</td>
<td>The services provided or arranged by the facility must meet professional standards of quality.</td>
</tr>
<tr>
<td>F 280</td>
<td>Resident #10 order clarified May 21, 2012 by Unit Manager Resident #9 Care plan updated May 22, 2012 by Speech Therapist and order written by Speech Therapy to allow resident to use straws. A full chart audit done by Unit Managers on May 24, 2012-May 25, 2012 of all charts to ensure PRN orders have indications. All PRN orders have indications and in compliance. Full audit of all residents with assistive eating devices are care planned. Charge Nurses educated by Staff Development RN to ensure all PRN orders have indications. Unit Managers educated by Director of Nursing May 29, 2012 to ensure care plans are updated as needed. Unit Managers will bring all new orders to morning meeting to ensure that indications are written on all PRN orders, and that diet changes are care planned. Charge Nurses educated by C N A s are properly trained on eating devices as needs change by June 1st 2012 by RN Staff Educator. All new orders will be brought to our daily morning meeting to ensure that all PRN orders have indications. Unit Managers will ensure that all new orders are brought to the daily morning meeting to ensure that all PRN orders have indications and care plans updated as needed. Director of Nursing will monitor compliance of PRN indications and updated care plans.</td>
</tr>
<tr>
<td>ID TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LBC IDENTIFYING INFORMATION)</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>F 281</td>
<td>Continued From page 3 indication for the administration of the Metamucil.</td>
</tr>
</tbody>
</table>

Medical record review of the physician's recapitulation order for April 2012, and May 2012, revealed, "Metamucil powder Oral As needed 2x (two times) 0.52 G" with no indication for the administration of the Metamucil.

Review of the facility's policy Guidelines for PRN Orders, last reviewed July 2009, revealed, "...PRN orders or related documentation shall specify the circumstances under which the medication shall be offered or given, in as much detail as is needed to give the medication properly..."

Interview and medical record review with the East Unit Manager on May 21, 2012, at 12:45 p.m., at the east nurse's station, confirmed there was no indication for the PRN Metamucil and the facility's policy for the PRN medication was not followed.


Medical record review and interview with the Director of Nursing on May 22, 2012, at 9:35 a.m., at the east nurse's station, confirmed there were no indications for the Metamucil prior to May 21, 2012, and the facility's policy for the PRN medications was not followed.

Resident #9 was admitted to the facility on
F 281 Continued From page 4
January 6, 2012, with diagnoses including Alzheimer's Disease, Dysphagia, and Depressive Disorder.

Review of the resident's care plan, revised April 17, 2012, revealed the resident was "At risk for aspiration related to Dysphagia." Continued review of the resident's care plan revealed intervention of "...Speech therapy interventions as needed."


Medical record review of the physician's recapitulation orders for May 1 to May 31, 2012, and signed by the physician on May 1, 2012, revealed, "2/15/12 ...No straws..."

Observation on May 21, 2012, at 12:45 p.m., in the Secured Unit dining area, revealed the resident sitting at a table and being fed by Certified Nurse Assistant (CNA) #4. Continued observation revealed the CNA holding a cup up to the resident's mouth with a straw in the cup and the resident drinking the fluid from the cup through a straw.

Review of the facility dietary sheet on the resident's tray May 21, 2012, at 12:52 p.m., revealed, "No Straws".

Interview with CNA #4 and Licensed Practical Nurse (LPN) #8, May 21, 2012, at 12:62 p.m., in the Secured Unit dining area, confirmed the dietary sheet revealed, "No straws", and the resident was offered and drank fluids from a cup...
SUMMIT VIEW OF FARRAGUT, LLC

F 281
Continued From page 5
with a straw against physician's orders.

F 323
483.25(h) FREE OF ACCIDENT
HAZARDS/SUPERVISION/DEVICES

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.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, facility documentation review, and interview, the facility failed to apply safety devices to prevent a fall for one (#20), failed to ensure safety devices were in place and immediately start post fall interventions for one (#9), and failed to maintain safe equipment in the shower room for one (#5) of twenty-three residents reviewed.

The facility's failure to ensure staff were instructed on how to apply safety devices and to ensure devices were in place resulted in harm when resident #20 fell and experienced a clavicle fracture and a scalp hematoma.

The findings included:

Resident #20 was admitted to the facility on November 18, 2011, with diagnoses including Traumatic Brain Injury, Acute Respiratory Failure, and Gastrostomy. The resident was discharged to home with Home Health on February 18, 2012.
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 323</td>
<td>Continued From page 6</td>
<td>Medical record review of the Minimum Data Set dated January 12, 2012, revealed the resident required extensive assistance with decision making, had short and long term memory problems, required extensive assistance of two persons for transfers, and the resident's balance was unsteady and only able to stabilize with human assistance.</td>
<td>F 323</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical record review revealed the resident had a history of a fall, prior to admission, resulting in a Traumatic Brain Injury.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical record review of a Physician's Order dated December 12, 2011, revealed, &quot;...Torso Support while in W/C (wheelchair)...&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Review of an Occupational Therapy's Plan of Care dated December 30, 2011, revealed, &quot;...Helmet to be worn at all times. PT (Patient) will self remove...&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Review of the facility's Fall Assessment dated December 10, 2011, revealed the resident scored a 20. Total score of 10 or above represents HIGH RISK for falls.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| | | Review of the facility's documentation dated December 28, 2011, revealed, "Res. (Resident) returned from the BR (bathroom) in W/C (wheelchair) by CNA (Certified Nursing Assistant) who had not replaced the Res. (resident's)...vest. The CNA stepped away from the resident to get assistance with the vest. The resident attempted to stand unassisted and hit the floor-right side of head...
(Right) forehead-hematoma cleansed...INTERVENTION: Staff education on helmet on at all times and torso support not in..." | | | |
Continued From page 7

Review of a Physician's Order dated December 28, 2011, revealed, "Transfer to the ER (Emergency Room) per family request."

Medical record review of a Nurse's Note dated December 28, 2011, at 4:30 p.m., revealed, "Res (Resident) sent to ER (Emergency Room) per family request. At 11:00 p.m., Res (Resident) returned...c/o (complained of) pain. Gave PRN (as needed) med. (medication)...N.O. (Nursing Order) for sling to remain on resident in..."

Review of a Radiology Report dated December 28, 2012, revealed, "...An oblique fracture is present through the distal right clavicle with about 7mm inferior displacement of the distal fracture fragment...DIAGNOSIS: Distal clavicle fracture..."


Review of a Radiology Report; from the Orthopedic Surgery, dated January 5, 2012, revealed, "Radiographs reveal a mildly to moderately displaced oblique fracture of the distal clavicle...DISPOSITION: "...will pursue conservative treatment...A sling will be used for comfort..."

Interview with the Certified Nursing Assistant (CNA) #2, (who was assigned to the resident on..."
F 323 Continued From page 8
December 28, 2011) on May 22, 2012, at 12:45 p.m., in the conference room, revealed, "The resident was wearing a...torso support. I removed it, assisted the resident to the bathroom then assisted the resident back to the wheelchair. I pushed the resident into the room to ask...(a nurse passing medications in the hall) to show me how the support was to be applied. I had never seen one like that before. I turned to ask the nurse and the resident fell out of the wheelchair," Continued interview, at that time, revealed,"I did not know...the resident) was to wear a helmet, no one told me." Continued interview confirmed the CNA had not received any instruction on the correct application of the torso support or the use of the helmet.

Interview with the Licensed Practical Nurse #2, (nurse giving medications on December 28, 2011) on May 22, 2012, at 12:50 p.m., in the conference room, confirmed the CNA had not applied the resident's helmet or torso support prior to placing the resident in the wheelchair. Continued interview revealed the CNA had not received any instruction on the application of the torso support or the use of the helmet.

Interview with the Director of Nursing on May 22, 2012, at 4:00 p.m., in the Director of Nursing's Office, confirmed the Certified Nursing Assistant failed to apply the resident's helmet and the torso support prior to placing the resident in the wheelchair, resulting in harm to the resident. C/O TN-29097

Resident #5 was readmitted to the facility on October 28, 2008, with diagnoses including PEG (Percutaneous Endoscopic Gastrostomy) Tube
F 323 Continued From page 9
Placement, Dysphasia (swallowing impairment), I.B.S. (Irritable Bowel Syndrome), Erosive Gastritis (inflammation in the stomach), Dementia, Alzheimer's Type, Osteoporosis, Glaucoma, Diabetes Mellitus, Type II, Vitamin D Deficiency, and Hypertension (High Blood Pressure).

Medical record review of the Minimum Data Set (MDS) dated November 1, 2011, revealed
"...Transfer and bathing supporting...Two plus person physical assist..."

Medical record review of a Fall Risk Assessment dated November 1, 2011, revealed the resident was at high risk for falls.

Medical record review of an Unusual Occurrences Nurse's Progress Note dated November 29, 2011, at 8:00 p.m., revealed
"...Resident was receiving shower and slid from shower chair into floor...Resident was assessed and neuro (neurological) checks started...WNL (Within Normal Limits); resident denies pain or injury...MD (Medical Doctor) and son...notified at 8:10 p.m. Will continue to monitor..."

Interview with Certified Nursing Assistant (CNA) #3 on May 22, 2012, at 4:10 p.m., in the West Wing Shower Room, confirmed resident #5 slid out of the reclining shower chair as the foot rest was broken. The resident was a scooper, was scopy, wet, and slick and started sliding onto the floor. The CNA left the resident to call for help, which was several feet away from the resident. CNA #3 stated the reclining shower chair foot rest had remained broken since November, 2011, had not written a work order for the maintenance
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Continued From page 10 director for the needed repair, and the broken reclining shower chair had been used since November 29, 2011, to shower resident #5 and other residents.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Interview on May 23, 2012, at 8:12 a.m., in the West Wing Shower Room, with the maintenance director, confirmed the reclining shower foot rest was broken, was not aware of it being broken, and had not received a work order to fix it.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Interview on May 23, 2012, at 1:05 p.m., with the maintenance director, at the West Wing nursing station, confirmed the chair could not be fixed and would have to be replaced.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Interview on May 23, 2012, at 1:29 p.m., with the Director of Nursing (DON), in the main conference room, confirmed the DON was unaware the reclining shower chair was broken and had been used to shower residents while broken since November 29, 2011. Continued interview confirmed no injuries occurred from the shower chair but use of the broken shower chair was a safety hazard.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Resident #9 was admitted to the facility on January 6, 2012, with diagnoses including Alzheimer's Disease, Dysphagia and Depressive Disorder.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical record review of the Minimum Data Set (MDS) dated April 11, 2012, revealed the resident had short and long-term memory problems, severely impaired cognition, and required supervision with transfers and ambulation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical record review of the Fall Risk Assessment dated January 6, 2012, revealed a</td>
</tr>
<tr>
<td>F 323</td>
<td>Continued From page 11 score of eleven, indicating the resident was at high risk for falls. Medical record review of a nurse’s note, dated March 16, 2012, at 10:40 p.m., revealed, “Pt (patient) was observed on floor...unwitnessed fall...Pt was c/o (complains of) arm pain and her wrist was swollen...MD (medical doctor) gave orders to send to (named hospital)...(Ambulance) p/u (pick-up) at 1700 (5:00 p.m.)...” Medical record review of a nurse’s note dated March 17, 2012, at 1:13 a.m., revealed, “Res. (resident) Returned from (named hospital) @ (at) 12:05 am via stretcher. Res. Alert with no s/s (signs/symptoms) or verbalization of pain or distress. R (right) arm with an immobilizer in place and secured at the waist to prevent movement of R shoulder...” Continued review of medical record revealed the resident was discharged from hospital with a diagnosis of dislocation of right shoulder. Medical record review and interview with Director of Nursing (DON), in the DON’s office, on May 22, 2012, at 3:40 p.m., revealed the resident had only one fall since being in the facility. Interview with the DON and review of the facility investigation on March 22, 2012, at 3:40 p.m., in the DON’s office, revealed documentation of orthostatic blood pressure (measure of blood pressure while lying, sitting and standing) was taken starting March 19, 2012, and continued for three days. Interview with the DON revealed orthostatic blood pressure monitoring was begun on Monday, March 19, 2012, three days after the resident had fallen on Friday, March 16, 2012.</td>
<td>F 323</td>
</tr>
</tbody>
</table>
F 323  Continued From page 12
Continued interview with the DON revealed that nursing staff were expected to implement post fall interventions immediately following a fall. Continued interview with the DON confirmed that orthostatic blood pressure monitoring was initiated on Monday, March 19, 2012, when facility staff became aware no other post fall interventions were initiated over the weekend. Continued interview with the DON confirmed the facility failed to initiate immediate interventions for the resident, and no interventions were initiated by the nursing staff upon the resident’s return from the hospital between Saturday, March 17, 2012, and Monday, March 19, 2012.

Review of resident #9’s care plan, revised January 20, 2012, revealed the resident was at risk for falls. Continued review of the resident’s care plan revealed the facility’s intervention for falls was “Hip protectors.” Continued review of the care plan, revised on April 17, 2012, revealed an intervention of “ambulates ad lib (as wants) with steady gait. Needs supervision. Hip protectors.”

Observation on May 21, 2012, at 11:28 a.m., in the Secure Unit dining area, revealed the resident was up and ambulating around the unit.

Observation on May 21, 2012, at 12:30 p.m., in the Secure Unit dining area, revealed the resident sitting at a table. Continued observation revealed the resident was not wearing the hip protectors.

Interview with Certified Nursing Assistant (CNA) #5, on May 21, 2012 at 12:30 p.m., in the Secure Unit dining area, confirmed the resident was not wearing the hip protectors, the resident usually
F 323 Continued From page 13
had the hip protectors on when ambulating on the unit, and the facility failed to follow the intervention as documented on the resident's care plan.

Interview with the Director of Nursing (DON), May 22, 2012, at 3:40 p.m., in the DON's office, confirmed the hip protectors were an intervention on the resident's care plan upon admission to the facility, and the resident should be wearing hip protectors.

F 371 FOOD PROCUREMENT, 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, the facility failed to provide sanitary storage of food and equipment and failed to maintain appropriate serving temperatures for food items on the buffet and tray line.

The findings included:
Observation of the dietary department on May 21, 2012, from 6:00 a.m. until 6:35 a.m., revealed:
1. Two 103 ounce cans of Salsa and one 108
F 371 Continued From page 14

A ounce can of Golden Hominy were dented and were available for use;
2. Eight of 11 different size ladles hanging on the pan storage rack had dried food debris and were available for use;
3. A 6 quart storage container of instant Potatoes stored under the prep table was not labeled;
4. A dietary aid placed frozen biscuits on a sheet pan with dried food debris on the pan.

Interview with the cook on May 21, 2012, at 6:35 a.m., in the dietary department, confirmed dented cans were to be removed from stock; the ladles needed to be cleaned; all storage containers were to be labeled with contents, and the dietary aid used a dirty sheet pan for the biscuits.

Continued observation of the dietary department on May 21, 2012, from 6:35 a.m. to 7:30 a.m., revealed:
1. A wire storage rack held 25 sheet pans with dried food debris on the pans, 1 of 2 large skilllets on the bottom shelf had a thick coating of grease on the exterior surface, a cobweb was hanging from the top shelf of the rack, 4 of 8 muffin tins had dried food debris, 2 of 2 large mixing bowls had dried food debris, and 5 of 11 quart pans had dried food debris;
2. One of 18 knives in a wall mounted knife storage box had a dried tomato seed on it;
3. A garbage can next to the ice machine was over flowing with garbage with the lid seting on top of the garbage;
4. The inside lip of the ice machine had wet, black debris;
5. Twenty-five of 25 ½ pint cartons of Buttermilk in the milk storage case expired on May 19, 2012.
F 371 Continued From page 15
and were available for resident use;
6. The large food mixer had dried food debris in the bottom of the bowl, on the back plate, and on the support legs;
7. A large zip lock bag of chocolate chips was in the dry storage and not sealed.

Interview with the dietary manager on May 21, 2012, at 7:30 a.m., in the dietary department, confirmed the cookware was not cleaned and available for use, the knife was not clean, the garbage can needed to be emptied, the ice machine needed to be cleaned, the Buttermilk was expired and available for use, the large food mixer needed to be cleaned, and the zip lock bag of chocolate chips was to be sealed.

Observation of the dietary department on May 21, 2012, from 9:45 a.m. until 10:00 a.m., revealed 5 of 10 half sandwiches stored in the walk in refrigerator were not sealed or labeled with a date.

Interview with the dietary manager on May 21, 2012, at 10:00 a.m., in the dietary department, confirmed there was no date to indicate when the sandwiches were made or expired.

Observation of food temperatures in the dietary department on May 21, 2012, between 11:25 a.m., and 11:50 a.m., on the tray line revealed:
1. Brown gravy at 133.5 degrees Fahrenheit (review of the temperature log revealed a temperature of 152 degrees Fahrenheit);
2. Tomato soup at 136.4 degrees Fahrenheit (review of the temperature log revealed a temperature of 180 degrees Fahrenheit);
3. Chicken noodle soup at 137.2 degrees Fahrenheit.
**F 371 Continued From page 16**

Fahrenheit (review of the temperature log revealed a temperature of 158 degrees Fahrenheit).

Interview with the dietary manager on May 21, 2012, at 11:50 a.m., in the dietary department confirmed the temperatures of the food on the tray line had fallen below acceptable temperatures since being placed on the steam table for service.

Observation of food temperatures in the dietary department on May 21, 2012, between 11:50 a.m., and 12:10 p.m., on the buffet line revealed mechanical meat at 138.4 degree Fahrenheit (review of the temperature log revealed a temperature of 152 degree Fahrenheit).

Interview with the dietary manager on May 21, 2012, at 12:10 p.m., in the dietary department, confirmed the temperature was below the acceptable range.

**F 372**

483.35(I)(3) DISPOSE GARBAGE & REFUSE PROPERLY

The facility must dispose of garbage and refuse properly.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, the facility failed to dispose of garbage and refuse properly to maintain sanitary conditions.

The findings included:

- Observation of the garbage and refuse

Dumpster door closed immediately and all materials placed into trash can for pickup later in the day.

All residents have the potential to be affected:

Environmental Services Supervisor and Dietary Manager will do walking rounds to ensure trash is properly secured in trash receptacles on a daily basis and will bring results to QA meeting to determine if continued Level of monitoring is necessary. In-service conducted for all staff to ensure dumpster door and trash is placed into proper receptacles by 6/1/2012 RN Staff Educator.

Maintenance Supervisor will bring results of daily walking rounds to Safety Committee meeting and Appropriate action will be taken if continued issues are going on.
SUMMIT VIEW OF FARRAGUT, LLC

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE
12022 KINGSTON PIKE
KNOXVILLE, TN 37923

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDERSUPPLIER/C
ID NUMBER:

445256

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

05/23/2012

(X3) DATE SURVEY COMPLETED

ID TAG

F 372

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

F 372

ID PREFIX TAG

F 372

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(DS) COMPLETION DATE

6/1/12

Continued From page 17,
dumpsters on May 21, 2012, from 10:00 a.m.
until 10:15 a.m., revealed the garbage dumpster
had one side sliding door completely open and
the opposite side partially open due to a bag of
garbage protruding from the door. Continued
observation revealed a bag of garbage protruding
from the lid of the dumpster which had broken
open with spillage onto the ground.

Interview with the dietary manager on May 21,
2012, at 10:15 a.m., at the dumpsters, confirmed
the doors of the dumpster were not closed and
garbage was not contained.

483.50(b), (d), (e) DRUG RECORDS,
LABEL/STORAGE DRUGS & BIOLOGICALS

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
have access to the keys.

F 431

483.50(b), (d), (e) DRUG RECORDS,
LABEL/STORAGE DRUGS & BIOLOGICALS

True test strips and control solution disposed
of May 21, 2012, and new bottles in place
with dates opened placed on container

Nursing staff educated on by Staff Development
to ensure proper way to label test strips and
control solution and to label when opened,
dispose if opened 3 months per manufacturer
recommendations

Charge Nurses will check strips and control
solutions daily to ensure that dates are on bottles,
dispose if no date found. Unit managers are to
inspect containers weekly to ensure compliance

Unit Managers will bring information about
disposal and dating to QA monthly. Director of
Nursing will perform spot checks monthly.
Continued From page 18

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 1970 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, review of manufacturer's recommendations, and interview, the facility failed to ensure Glucose Control and Test Strips were dated with the opened date for four out of six medication carts.

The findings included:

Observation of the medication cart (for the even side room numbers), on May 21, 2012, at 11:30 a.m., on the Secured Unit, revealed the True Test glucose control strips and the True Test strips were not dated when opened.

Review of the manufacturer's recommendation, dated 2011, revealed "...write date opened on Control label...Discard if either 3 months after opening or after date printed next to Expiration on label has passed...Write date opened on Strip vial...Discard unused Strips from vial if either 4 months after opening or after date printed next to Expiration on label has passed...Use of Strips past either date may give incorrect results..."
Continued From page 19
Interview on May 21, 2012, with Licensed Practical Nurse (LPN) #5, at 11:30 a.m., in the nurse's station, confirmed the control solution and the test strips were not dated when opened.

Observation of the medication cart (for the odd side room numbers), on May 21, 2012, at 11:45 a.m., on the Secured Unit, revealed the True Test glucose control strips and the True Test strips were not dated when opened.

Interview on May 21, 2012, with Licensed Practical Nurse (LPN) #5, at 11:45 a.m., in the nurse's station, confirmed the control solution and the test strips were not dated when opened.

Observation of the medication cart (for the even side room numbers), on May 21, 2012, at 12:30 p.m., on the East Hallway, revealed the True Test glucose control strips and the True Test strips were not dated when opened.

Interview on May 21, 2012, with Licensed Practical Nurse (LPN) #3, at 12:35 p.m., in the East Hallway nurse's station, confirmed the control solution and the test strips were not dated when opened.

Observation of the medication cart (for the odd side room numbers), on May 21, 2012, at 12:55 a.m., on the East Hallway, revealed the True Test glucose control strips and the True Test strips were not dated when opened.

Interview on May 21, 2012, with Licensed Practical Nurse (LPN) #6, at 12:55 p.m., in the East Hallway nurse's station, confirmed the control solution and the test strips were not dated when
F 431 Continued From page 20

opened.

Interview on May 21, 2012, with the Director of Nursing (DON), at 2:30 p.m., in the conference room, confirmed the control solution and test strips for the four medication carts were not dated when opened and the manufacturer's recommendations were not followed.

F 441 SS=O

483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program

The facility must establish an Infection Control Program under which it:

1. Investigates, controls, and prevents infections in the facility;
2. Decides what procedures, such as isolation, should be applied to an individual resident; and
3. Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection

1. When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
2. The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
3. The facility must require staff to wash their hands after each direct resident contact for which

F 441

LPN #2 educated immediately on May 21, 2012 to ensure hand washing before and after each resident contact. Resident #12 orange "C" sign placed on door.

LPN #2 educated by Director of Nursing on proper hand washing policy/protocol on May 29, 2012. Charge Nurses educated by June 1st, 2012 by Staff Development RN on hand washing policy/protocol and correctly identifying residents on contact precautions with an orange "C" on the door.

Staff educator will ensure compliance by monitoring med passes with med audits monthly and monitored at Quality Assurance. Infection control in-services are conducted yearly, for new hires and on an as needed basis. Charge Nurses and Unit Managers will do walking rounds daily to check for identifiers on door for contact precaution resident. A list of isolation residents will be added to the Nurse Communication book to ensure compliance.

Unit Manager will bring results of audits to Quality Assurance monthly. Director of Nursing will monitor compliance. Unit Managers and Charge Nurses will monitor contact isolation rooms and ensure an orange "C" on door.
SUMMIT VIEW OF FARRAGUT, LLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CMS IDENTIFICATION NUMBER

445258

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY COMPLETED

05/23/2012

F 441

Continued From page 21

hand washing is indicated by accepted professional practice.

(c) Linens

Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, facility policy review, observation, and interview, the facility failed to post contact isolation signage for one resident (#12), and failed to maintain hand hygiene during medication administration for four random residents (B, C, D, E) of twenty four residents reviewed.

The findings included:

Resident #12 was admitted to the facility on May 18, 2012, with diagnoses including Neuropathy, Osteomyelitis, Diabetes Mellitus, and Methicillin Resistant Staphylococcus Aureus (MRSA).

Review of facility policy, Guidelines for Isolation-Categories of Transmission-Based Precautions, last revised August 2009, revealed "...signs-used color coded signs...to alert...orange is the color code for Contact Precautions...place...at the dooryard instructing visitors to report to the nurse's station before entering the room..."

Observation on May 21, 2012, at 8:00 a.m., revealed the resident had a cart with personal
**F 441** Continued From page 22

protective equipment outside the resident's room.

Interview with Certified Nursing Assistant #1 (CNA) on May 21, 2012, at 6:00 a.m., outside the resident's room, confirmed the resident was in contact isolation for MRSA and the door was "suppose to have a sign on the door indicating the resident was in isolation. Further interview confirmed, "I guess they didn't put one up."

Interview with Licensed Practical Nurse (LPN) #1 on May 21, 2012, at 6:10 a.m., outside the resident's room, confirmed "there was usually a letter C (indicating contact isolation) on the door, should be one there."

Interview with the Director of Nursing (DON) on May 22, 2012, at 7:15 a.m., outside the DON's office, confirmed "residents in contact isolation should have a cart outside the room and a sign on the door with a letter C on it."

Observation on May 21, 2012 during the 1:00 P.M. medication administration, on the east wing half revealed, Licensed Practical Nurse #3 (LPN) set up and administered oral medications to Resident #B without washing the hands. LPN #3 returned to the medication cart, accessed medications for resident #C, entered the residents room and administered oral medications to resident #C without washing the hands. Continued observation revealed, LPN #3 returned to the medication cart, accessed medications for resident #D, entered the resident's room and administered oral medications without washing the hands. Continued observation revealed, LPN #3 returned to the medication cart, accessed medications for
F 441  Continued From page 23
Resident #E, entered the resident's room, donned gloves, accessed the resident's gastrostomy tube, and administered medications via gastrostomy tube without washing the hands.

Review of the facility policy, Guidelines for Standard Precautions revealed, "... hand washing ...wash hands after gloves are removed, between resident contacts and when otherwise indicated ..."

Interview with LPN #3, on May 21, 2012, at 1:39 P.M., in the east wing hallway, confirmed hands were to be washed prior to beginning medication administration, and between resident contacts during the medication administration. Continued interview confirmed hands were to be washed prior to donning gloves, and accessing medical devices.

F 514  483.75(i)(1) RES
SS=D  RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 514</td>
<td>Continued From page 24</td>
</tr>
</tbody>
</table>

Based on medical record review, observation, and interview the facility failed to ensure accurate documentation on the Medication Administration Record (MAR) for one resident (ID 12) and failed to ensure the accurate documentation of the Do Not Resuscitate order for one resident (ID 3) of twenty-four residents reviewed.

The findings included:

- Resident #12 was admitted to the facility on May 18, 2012, with diagnoses including Neuropathy, Osteomyelitis, Diabetes Mellitus, and Methicillin Resistant Staphylococcus Aureus (MRSA).

- Medical record review of a MAR for May 18, 2012 through May 21, 2012, revealed "...Vancomycin 1750 mg (milligrams)..."

- Observation on May 21, 2012, at 9:38 a.m., in the resident's room, revealed Vancomycin 1500 mg in 500 cc (cubic centimeters) of Normal Saline infusing at 250 cc's per hour.

- Interview with Licensed Practical Nurse (LPN) #2 on May 21, 2012, at 1:20 p.m., at the West Wing Nurse's Station, confirmed the order on the MAR is for Vancomycin 1750 mg and the resident received Vancomycin 1500 mg on May 19, 2012 through May 21, 2012.

- Interview with Unit Manager #1 on May 21, 2012, at 1:32 p.m., in the Administration Office, confirmed the "pharmacy changed the dosage order on May 18, 2012 to Vancomycin 1500 mg, but did not change it on the MAR."
F 514 Continued From page 25
Resident #5 was admitted to the facility on April 18, 2012, for diagnoses including Chronic Ischemic Heart Disease, Muscle Weakness, Dementia, and ines.

Medical record review of a signed Physicians Orders for Scope of Treatment (POST) for April 18, 2012, revealed: "...Code Status: Resuscitate...Full Treatment..."

Medical record review and interview with Licensed Practical Nurse (LPN) #2 on May 21, 2012, at 2:15 p.m., at the West Wing Nurse’s Station, confirmed the resident’s bound medical record had a round green sticker on the binding of the medical record and the sticker indicated the resident was a full code.

Medical record review of the signed Physician’s Recapitulation Order Sheet for May 2012, revealed "...DNR (do not resuscitate)..."

Interview with the Director of Nursing (DON) on May 22, 2012, at 9:34 a.m., at the East Wing Nurse’s Station, confirmed the resident was a full code and the physician’s recapitulation orders indicated the resident is a DNR and the POST form indicated the resident was a full code.