### F 000 INITIAL COMMENTS

During investigation of Entity Reports #25761, #25964, #25503, #25338, #25273, #24893, #24870, #25476, and Complaints #24857, #25546 at Hillcrest North on June 9-11, 2010, no deficiencies were cited under 42 CFR Part 482.13 Requirements for Long Term Care.

### F 514 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 by:
  - Based on medical record review and interview, the facility failed to maintain an accurate medical record for one resident (#5) and a complete medical record for one resident (#6) of fifteen sampled residents.

- The findings included:
  - Resident #5 was admitted to the facility on April 18, 2010, with diagnoses including Congestive Heart Failure and Chronic Obstructive Asthma. Medical record review of a nurse's note dated...
June 24, 2010, at 8:10 p.m., revealed the resident was transported to a hospital. Medical record review of a nurse's note dated June 24, 2010, at 11:40 p.m., revealed, "Pt is being admitted..."

Medical record review revealed the resident did not return to the facility. Medical record review of a treatment record dated June 26, 2010, revealed a first shift nurse initiated a skin treatment as administered.

Resident #6 was admitted to the facility on November 23, 2009, with diagnoses including Diabetes Mellitus and Obstructive Sleep Apnea. Medical record review of a physician's order dated December 16, 2009, revealed, "dc (discharge) today to KARM (Knox Area Rescue Ministries)." Medical record review of a nurse's note dated December 16, 2009, at 10:15 a.m., revealed, "A and O x 3 (alert and oriented times three) resp (respirations) even unlabored." Medical record review revealed no documentation regarding when the resident was discharged or the condition of the resident at the time of discharge.

Interview with the director of nursing on June 11, 2010, at 11:15 a.m., in the lower level room adjacent to the elevator, confirmed Resident #6's medical record was inaccurate, and Resident #6's medical record was incomplete.

C/O: #25715