<table>
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<tr>
<th>ID PREFIX</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 164</td>
<td>463.10(e), 463.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</td>
<td>F 164</td>
<td>463.10(e), 463.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</td>
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The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (2) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another healthcare institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law, third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:

Based on policy review and observations, it was determined the facility failed to maintain residents' privacy for 1 of 8 (Resident #3) sampled residents and 1 Random Residency (RR #2) observed during medication administration and 1 of 1 (Resident #10) sampled residents observed during a

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 patient. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the data of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 45 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continue program participation.
Continued From page 1
dressing change.

The findings included:

1. Review of the facility's "RESIDENT RIGHTS" policy documented "...(a) To [provide] privacy in treatment and personal care..."

2. Observations in RR #2's room on 5/24/10 at 6:10 PM, revealed Nurse #2 did not close the door of RR #2's room or pull the privacy curtain during the administration of insulin to RR #2.

3. Observations in Resident #3's room on 5/25/10 at 9:16 AM, revealed Nurse #4 did not close the door of Resident #3's room during administration of eye drops to RR #2.

4. Observations in Resident #10's room on 5/25/10 at 10:10 AM, revealed Nurse #9 did not pull the curtain to the outside window during a dressing change. Resident #3 was in full view to anyone that walked by on the sidewalk outside Resident #10's window.

483.13(c)(1)(ii)-(iii), (c)(2)-(4)

INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

F 225
FS=D

483.13(c)(1)(ii)-(iii), (c)(2)-(4)

INVESTIGATE/REPORT ALLEGATION/INDIVIDUALS

Requirement
The facility will ensure a thorough investigation is completed for injuries of unknown origin and incidents not witnessed by staff.

Continued on page 3
Continued from page 2

**F 225**

Corrective Action

1. The Fall Management Team and nursing management were provided in-service education by the Administrator on 5/27/10 regarding conducting a thorough investigation into injuries of unknown origin and incidents not witnessed by staff to determine the root cause.

2. The licensed nurses were provided in-service education by the Administrator, ADON, SDC and RM on 5/28/10, 5/29/10, 5/30/10, 5/31/10, 6/4/10 and 6/7/10 regarding conducting a thorough investigation into injuries of unknown origin and incidents not witnessed by staff to determine the root cause.

3. Event notes will be reviewed each morning M-F by the QA&A Committee for compliance with completion, investigation, documentation and intervention based on root cause.

4. The DON, ADON and nurse management will monitor for compliance weekly during team meetings.

**COMPLETION DATE 6/7/10**
**LEWIS COUNTY MANOR**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
119 KITTRELL ST, PO BOX 129
HOHENWALD, TN 38462

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<th>ID PREFIX</th>
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1. Medical record review for Resident #1 documented an admission date of 3/30/07 with diagnoses of Incessant Pacing, Multiple Falls, Hypertension, Hyperlipidemia, Congestive Obstructive Pulmonary Disease, Dementia and Osteoarthritis. Review of the Minimum Data Set (MDS) dated 3/24/10 assessed Resident #1 with short term and long term memory problems and was moderately impaired in decision making. She was also assessed as needing extensive assistance with transfers, activities of daily living and ambulation.

Review of the Care Plan dated 7/6/09 to the present documented, "Problem/Strengths... Risk for falls due to unsteady gait and h/o [history of] fracture..." The Care Plan documented 16 falls had occurred since 1/1/10.

Review of Resident #1’s Nurse’s Event Notes documented the following:

a. 4/4/10 at 3:50 PM, "...called to p/t’s [patient’s] room by another pt who heard pt fall. Pt was laying on floor with [c] head by the door... foot rest on the recliner was up. Pt has hemaroma to top R [right] side of head. Neurochecks started. Pt is not to be left in recliner with it reclined s [without] a CNA [Certified Nursing Assistant] present."

b. 6/8/10 at 10:45 PM, "...CNA was changing pt on their last round when noticed skin tear to Rt [right] elbow. Upon assessment 2 cm [centimeter] x [by] 0.1 cm skin tear noted to Rt elbow. Small amount of dried blood around area noted... Pt unable to tell this writer how skin tear acquired d/t [due to] cognitive status..."

c. 5/15/10 at 4:50 PM, "fell, obtained skin tear to left arm, bruising to left shoulder and laceration above left eye, neurochecks initiated, pt sent to ER [Emergency Room] and admitted for..."
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<tr>
<th>(X4) ID PREFIX</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEGAL IDENTIFYING INFORMATION)</th>
<th>ID PREFIX</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<td>F 225</td>
<td>Continued From page 4 observation. d. 5/16/10, &quot;Returned from hospital with sutures to left temple c new orders to remove sutures in 10 days.&quot; Review of the physician's orders dated 5/15/10 documented &quot;send to [named ER] r/t [related to] laceration to left temple &amp; [and] shoulder pain... Admit to [named hospital] for observation.&quot; The facility was unable to provide a thorough investigation into the incidents on 4/4/10, 5/8/10 and 5/16/10. 2. Medical record review for Resident #7 documented an admission date of 9/29/08 with diagnoses of Osteoarthritis, Degenerative Joint Disease, Bipolar Disorder, Bilateral Cataracts, Congestive Heart Failure, Chemical Dependency, Crohn's Disease, Chronic Lung Disease, Diabetes, Diverticulosis, Emphysema, Stress Fracture Foot, Gastroesophageal Reflux Disease, Herniated Lumbar Disc, Cardiac Murmur, Hypercholesterolemia, History of Osteoporosis with Fracture, and History of Pneumonia. Review of the MDS dated 4/6/10 assessed Resident #7 with short term memory problems and was moderately impaired in decision making. She was assessed as needing extensive assistance with transfers, activities of daily living, and ambulation. Review of the Nurse's Event Note dated 3/25/10 at 4:30 AM documented, &quot;CNA came and reported to this writer that patient in room 425B had fell... pt stated was standing in line for smoke break and then I fell asleep &amp; fell down...&quot; and a new intervention of &quot;Reorient pt to smoking times and redirect pt to bed.&quot; Further review of nurses notes dated 3/25/10 documented &quot;...called</td>
<td>F 225</td>
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Continued From page 5
[named doctor] & he said to send her to [named clinic] to be seen..." and then documented "[Named doctor] called & stated that she had Fr [fracture] to L [left] Humerus..."

Review of the Occurrence Investigation dated 3/26/10 for Resident #7's incident of 3/25/10 did not document a thorough investigation regarding this incident which resulted in the resident having a fractured arm.

Review of the Nurse's Event Note dated 4/12/10 at 12:00 AM documented "Resident stated she fell & hit her head on bed, was unobserved. O [no] c/o [complaints of] pain voiced." and a new intervention of "Made resident aware to use call light & let staff know her needs."

Review of a CNA's statement on 4/12/10 at 12:35 AM revealed "...I informed [named nurse] of this incident... I noticed water and blood on the floor, there was blood on the blanket at foot of the bed..." There was no mention of any injury or blood on the 4/12/10 at 12:00 AM Nurse's Event Note.

Review of the Nurse's Event Note dated 4/12/10 at 10:40 AM documented, "Co-nurse noted that patient had an area on her elbow area noted to be a laceration c [with] dried blood around it upon asking patient she stated that it had happened from her previous fall early am..." Nurses notes dated 4/12/10 at 9:30 PM documented "...Received 6 stitches to R [right] arm..."

Review of the Occurrence Investigations dated 4/12/10 for Resident #7's incident did not document a thorough investigation of this incident in which Resident #7 had a laceration to the right
Continued from page 6

arm requiring sutures and the incident was not reported to the state.

During an interview in front of the Administrator's office on 5/27/10 at 2:15 PM, the Assistant Director of Nursing (ADON) and the Administrator were asked if unreported injuries were reported to the state. The Administrator stated "no, we do not have to report unless it is abuse, fire, or without water for 8 hours."

3. Medical record review for Resident #20 documented an admission date of 3/10/10 with diagnoses of Hypertension, Depression, Anxiety, Gastroesophageal Reflux, Osteoarthritis, Diverticulitis, Dementia, and Cellulitis. Review of the MDS dated 3/22/10 and 6/19/10 documented Resident #20 had short term memory problems and was moderately impaired in decision making. The MDS dated 3/22/10 documented extensive assistance with transfers, activities of daily living, and limited assistance with ambulation.


Review of the Occurrence investigation dated 4/10/10 did not document a thorough
Continued From page 7

Investigation regarding this 4/10/10 incident.

Nurses Progress Notes dated 4/20/10 "Continues to be unable to bear weight on L [left] leg. Cries out in pain when leg is touched... EMS [Emergency Medical Services] here to transport to [named hospital]..." Review of X-ray report dated 4/20/10 documented "Findings: There is an impacted fracture of the left subcapital femoral neck... Generalize osteoporosis." There was no documentation of a thorough investigation into this incident.

During an interview in front of the Administrator's office on 5/27/10 at 2:15 PM, the ADON and the Administrator were asked if unwitnessed incidents were reported to the state. The Administrator stated "No, we do not have to report unless it is abuse, fire, or without water for 8 hours."

483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individually.

This REQUIREMENT is not met as evidenced by:

Based on review of the "Medication Guide for the Long - Term Care Nurse" and observation, it was determined the facility failed to ensure 3 of 11 nurses (Nurses #1, 3, and 9) maintained residents' dignity and respect by entering residents' rooms without knocking or gaining permission prior to entering the residents' room.

Continued on page 9
F 241 Continued From page 8
The findings included:

1. Review of "Medication Guide for the Long-Term Care Nurse", page 64 documented "...11. The nurse should knock on the resident's door before entering..."

2. Observations during medication administration on 5/17/10 at 4:40 PM, Nurse #1 entered Random Resident (RR) #1's room without knocking on the door or gaining permission to enter.

3. Observations during medication administration on 5/17/10 at 4:55 PM, Nurse #3 entered RR #3's room without knocking on the door or gaining permission to enter.

4. Observations during medication administration on 5/19/10 at 7:55 AM, Nurse #9 entered RR #9's room without knocking on the door or gaining permission to enter.

F 250 Continued from page 8
F241
Corrective Action
1. Individual in-service education was provided for Nurse #1 and #3 on 6/4/10 and #9 on 5/25/10 by the Administrator regarding knocking or gaining permission to enter a resident’s room.

2. The licensed nurses were provided in-service education by the Administrator and SDC on 5/28/10, 6/4/10 and 6/7/10 regarding knocking or gaining permission to enter a resident’s room.

3. A Medication Administration and Treatment audit to be performed by the DON, ADON, SDC and RM on each licensed nurse 6/4/10 to 6/15/10 with a focus on knocking or gaining permission prior to entering a resident room.

4. The DON, ADON and nurse management will monitor for compliance during daily observation rounds and report the findings to the QA&A Committee quarterly.

F 250
483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE

The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to provide medically related social service interventions related to behaviors for 4 of 33 (Residents #1, 29, 31 and 32) sampled residents.

COMPLETION DATE 6/15/10
The findings included:

1. Medical record review for Resident #1 documented an admission date of 3/30/07 with diagnosis of Incessant Pacing, Multiple Falls, Hypertension, Chronic Obstructive Pulmonary Disease, Dementia and Osteoarthritis. Review of the Minimum Data Set (MDS) dated 3/24/10 for Resident #1 documented short term and long term memory problems and moderately impaired decision making.


Review of "Occurrence Investigation" for the 3/2/10 incident documented "...patient wanders, redirected to room often... When patient in room 401A told her to leave she hit patient in 401A on arm. Patients were separated. No injuries noted..."

Review of Nurse Event Notes dated 3/25/10 12:00 PM "...Pt was wandering in hallway & wandered into Rm [room] 417. Pt. in Rm 417B was in the hallway & went into rm after (p) [after] pt. LPN [Licensed Practical Nurse] told pt in 417B to wait for her. Pt in 417B went into rm & started yells @ pt [at] pt to get out. Pt then started slapping @ pt in 417B who grabbed her on the forearm. Pt can't [continue] to slap pt in 417B. Pts were then separated by LPN."
Continued From page 10

Review of "Occurrence Investigation" for 3/25/10 incident documented "...patient assisted to room per staff assisted c [with] meal. patient fell asleep after p meal.

Review of Nurse Event Notes dated 4/5/10 at 2:55 PM "...CNA heard patient yelling and went into the room. This pt [Resident #1] was sitting on 420B bed and pt in 420B was trying to stop this pt from taking her stuff. Pt then started hitting [named other pt] right arm. No areas of bruising noted. Pt separated from each other c success.

Review of Nurse Event Notes documented the following incidents:
   a. 5/6/10 at 1:46 PM "...Rehab [Rehabilitation] technician heard patient yelling and went into the room and noted patient slapping another patient on the chest."
   b. 6/11/10 at 12:30 PM "...CNA heard patient yelling and went to the room 402 and CNA witnessed pt in room 403A hit this pt on her back. Pt redirected.

Review of the Comprehensive Care Plan dated 7/8/09 to present documented the following incidents without injury:
   a. 1/13/10 "...noted to be pacing halls on this day & slapped another patient on left upper arm..."
   b. 1/15/10 "...physical altercation with another patient..."
   c. 1/21/10 "...physical altercation with another patient. This patient hit patient in another room right forearm..."
   d. 1/24/10 "...combative during care causing a skin tear..."
   e. 2/19/10 "...wandered into another patient's room, physical altercation between these two
Continued From page 11

patients...

f. 2/22/10 "...physical altercation with another patient..."
g. 4/5/10 "...physical altercation with another pt. This pt was in another pt's room taking stuff & other pt attempted to stop pt & this pt slapped other pt's right arm..."
h. 5/5/10 "...This pt hit another pt in chest..."
i. 5/11/10 "...This pt wandered into another pt's room, other pt hit this patient in the back..."
The interventions for the behaviors documented on 1/13/10, 1/15/10, 2/19/10, 2/22/10, 5/5/10, and 5/11/10 were to redirect the resident.

Review of quarterly "Social Services Notes" dated 3/25/10 documented, "...Patient is up daily and ambulates per self. Patient tends to wander frequently and has an antiwander guard. Patient will also wander in other patient's rooms and is hard to redirect at times... MDS and care plan reviewed. No significant changes noted. No current needs noted. Social Services (SS) to continue to visit and monitor to ensure needs are met."

During an interview in the fine dining room on 5/28/10 at 7:00 PM, the Social Service Director (SSD) stated, "We redirect her [Resident #1] quite a bit... I'm not sure how much she understands..."
The SSD further stated that they frequently have staff sit with her. The SSD was asked what happens on the night shift at 2:00 AM and the facility does not have sufficient staff to sit with her. The SSD stated, "The charge nurse would have to decide what to do..."

During a telephone interview in the fine dining room on 5/27/10 at 11:55 AM, the Licensed Clinical Social Worker stated, "I used to see her..."
Continued From page 12
[Resident #]1 years ago. I discharged resident because I could not interact with her."

2. Medical record review for Resident #29 documented an admission date of 12/1/09 with
diagnoses of Diabetes, Rheumatoid Arthritis, Seizures, and Dementia. Review of
Recertification Physician's orders dated 12/1/09, 1/7/10, and 4/1/10 documented, "MENTAL
HEALTH TO EVAL [evaluate] AND TREAT AS
INDICATED."

Review of the nurses notes documented the following:
a. 12/2/09 at 8:00 PM "...Pt demanding LorTab, states he took it every 2 hrs [hours] at home. Pt
states, "I am leaving here."
b. 12/2/09 at 8:15 PM "...Pt dressed to leave, crying, states he is depressed because his
daughter killed herself a year ago..."
c. 12/4/09 at 9:00 PM "...pt states he is leaving here tomorrow if we do not help him..."
d. 12/7/09 at 4:36 AM "...pt states to CNA nurse
did not give him his pain med [medication] now, he would come and get it; when informed pain
medication is not due yet pt replied, 'that's bull...
curse word]' Pt is walking up and down the
hallway at this time."
e. 12/12/09 at 8:50 PM "...Pt crying with another
daughter at this time..."
f. 12/20/09 at 11:00 PM "...Pt immediately started
to curse and stated, 'Don't tell me that G... d...
curse words] if, I know it is time for my pill..."
g. 12/27/09 at 2:00 AM "...Pt very agitated and
cursed at CNA assigned to hall..."
h. 1/14/10 at 1:30 PM "...Pt outside in front of
facility smoking... had cigarette and lighter in his
room..."
i. 1/31/10 at 1:50 AM "...Pt requested a sandwich
Continued From page 13

and milk, became agitated when CNA could not assist him until after vital signs. Pt became more agitated and began cursing and walked back to room cursing the whole way...

j. 2/18/10 at 3:15 PM "...When CNA told pt she wasn't allowed in the kitchen to cook chicken strips, pt began cursing CNA..."

k. 3/1/10 at 12:15 PM "...Pt became agitated and raised his voice and cursing because pain med could not be given at this time..."

l. 3/1/10 at 12:15 PM "...Reported by CNA that pt demanded cigarettes from other resident's supply and began to curse CNA..."

m. 3/2/10 at 9:00 PM "...Pt stated he does not have anything to live for, I can't get the help I need and I feel pretty bad about it. Pt crying..."

n. 4/10/10 at 2:00 AM "...Pt at desk demanding to smoke, when told no, pt cursed writer stating "F... [curse word] B... [curse word]..."

o. 4/20/10 at 5:15 PM "...Pt became upset because pain medication was 15 minutes late, resident started yelling and cursing, stating, "Stupid B... [curse word], I know now why your old man beat you up, he should of killed you. I know all about you, you fat lazy b... [curse word]..."

p. 5/14/10 at 4:00 AM "...Pt at desk cursing..."

q. 5/24/10 at 7:45 PM "...Pt trying to leave facility, very agitated, cursing..."

There was no documentation found in the five social progress notes since admission addressing behavior modification interventions; need for medically related social services related to the suicide of the resident's daughter and grief counseling; and making referral to the contract Psychiatrist for counseling services in a timely manner.

During an interview in the Social Worker's (SW)
Continued From page 14

office on 9/27/10 at 10:25 AM, the SW stated, "I don't know why mental health services were not started any earlier than 5/6/10, the nurses should of done that."

3. Medical record review for Resident #31 documented an admission date of 5/10/08 with diagnoses of Vascular Dementia with Behavioral Disturbance, Mood Disorder, Non-Insulin Dependent Diabetes Mellitus, Glaucoma, Gastrointestinal Reflux Disease, Hypothyroidism, Hyperlipidemia and Dementia with Behavioral Disturbance.

Review of the nurse's notes documented the following:
- a. 4/1/10 at 2:10 PM "...Refused to have vital signs taken by staff...".
- b. 4/5/10 at 2:20 AM "...Patient refused to have V/S [vital signs] taken x [times] 2 attempts..."
- c. 4/5/10 at 6:50 PM "...VS were refused. Pt [patient] had 2 altercations...Pt separated from other residents involved..."
- d. 4/7/10 at 5:30 PM "VS were refused this shift..."

Review of Resident #31's MDS dated 4/2/10 documented the resident had short and long-term memory loss and moderately impaired in decision making.

Review of Cars Plan dated 4/2/10 to present documented the following:
- a. 4/2/10 "...Risk for side effects from psychotropic medication use" Interventions "...Patient picks + [and] pokes at staff + other patients + laughs silent as needed."
- b. 4/6/10 "p) [problem] physical altercation with another patient + caused a skin tear to other
| F 250 | Continued From page 15 

patient, ...Goal's Staff will monitor behavior + provide interventions as indicated when exhibiting physically aggressive behavior." The only interventions "Cont [continue] to monitor for physically aggressive behavior + redirect + separate as needed...Cont to monitor redirect when exhibiting physically aggressive behavior. Provide divisional activities." c. 5/13/10 "p) staff went to assist patient to her room, became agitated + proceeded to sit down in the floor with CNA assistance pt then proceeded to lie back CNA's X [times] 5 + Nurses X 2 assisted patient out of floor..." 

Review of Social Services Notes documented the following:

a. 1/5/10 "MDS and Care Plan reviewed, no significant change noted. No current problems or need noted. SS to continue with visitation and monitor."

b. 1/15/10 "60 day note: Patient remains on skilled services, MDS and Care Plan reviewed. No significant changes noted. SS to continue with 1: [on] 1 and monitor to ensure needs are met" c. 1/17/10 "D/C [discontinue] from SNF [skilled nurses facility] to ICF [Intermediate Care Facility]"

d. 3/24/10 "Order given to D/C Serquel... start Zypraxa... start Alivan..."

e. 4/2/10 "Quarterly note: Patient is up daily and ambulates per self. Patient eats meals in back dining room with assistance. Patient attends activities with reminding. Patient tends to wander a lot and is not always easily redirectable. Patient refuses vital signs, care and meds [medications] at times... No significant changes noted. SS to continue to visit with and monitor."

f. 4/8/10 "Patient was involved in 2 altercations this date. Patient slapped resident in room 112A. No injuries and patients were separated. Patient

| F 250 |
Continued From page 16

also hit patient in room 422B causing skin tear. Patients are to be kept separated all times. This is the last SS note in the chart.

During an interview in Random Resident (RR) #26's room on 5/26/10 at 9:00 PM, RR #26 stated, "[Resident 31] has gotten in bed with me and roommate. Has hit me. I reported this. More than once... Once nurse saw this happen."

During this interview in RR #26's room on 5/26/10 at 9:00 PM, Resident #31 came to RR #26's room and turned on light and then came into the room. Both RR #26 and roommate had to tell her [Resident #31] to get out.

There was no documentation in the Social Services Notes addressing behavior modification interventions for Resident #31.

4. Medical record review for Resident #32 documented an admission date of 8/4/08 with diagnoses of Osteoporosis, Head Injury, History of Fractured Ribs, Hypertension, Alcohol Dependancy, Chronic Obstructive Lung Disease, History of Lung Cancer, Dementia with Psychosis, Diabetes Mellitus, Bipolar Affective Disorder, Schizophrenia, Osteoarthritis, Gastroesophageal Reflux Disease, Cerebrovascular Accident, Depression, Seizure Disorder, and Acute Renal Failure. Review of the MDS dated 4/29/10 documented "exhibited persistent anger with self or others" for up to 5 days a week and "socially inappropriate/disruptive behavioral symptoms" for 1 to 3 days in the last 7 days.

Review of the nurses notes documented the following:
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<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
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| F 250 | Continued From page 17  
   a. 3/1/10 at 7:00 PM "...Pt is agitated. Wanted to go to smoke 30 mins [minutes] earlier when redirected got ill. Will cont to monitor."  
   b. 4/13/10 at 1:00 AM "...Patient was very loudly yelling, being rude, cursing at staff she thought it was that to eat, we gave a sandwich and cup of juice, she finally went to sleep."  
   c. 5/20/10 at 9:00 AM "...pt yelling at this writer about her medications patient stated 'you did not give me my d... [curse word] medications' attempted to explain to patient that she had received her 9 am meds [medications] and another staff member witnessed it as well. pt remained agitated..."  
   Review of the Care Plan dated 8/17/09 to present documented the following:  
   a. 1/10/10 "p) Refused incontinence care or bath, physically aggressive towards staff & verbally aggressive, pt left alone."  
   b. 1/4/10 "p) overheard by staff telling roommate she was going to hurt her, 1:1 provided & pt states she wouldn't do that she loves her roommate."  
   c. 2/4/10 "p) cont to be verbally aggressive towards staff cont frequent meal and medication refusal" and documented an intervention of "staff to cont to monitor behavior & keep MD [Medical Doctor] aware."  
   d. 5/20/10 "p) yelling at nurse stating she didn't get her medicine reassured pt" and documented an intervention of "Provide reassurance & reminding regarding medication as needed."  
   Review of the Social Services Notes documented the following:  
   a. 1/3/10 "Patient refusing to be changed... and refused to take bath. Patient attempted to hit CNA and calling them b... [curse word] ...1:1 done and
F 250 Continued From page 18 to monitor.
   b. 1/4/10 documented, "Patient overheard by staff she was going to hurt roommate, She denied this to nursing and this writer. To monitor."
   c. 2/5/10 "Quarterly note... Patient has been exhibiting a lot of behaviors such as yelling, cursing staff, being un-cooperative and not redirectable... SS to continue to visit and attempt redirection as needed and provide reassurance."
   d. 4/30/10 "Quarterly note... SS to continue to visit 1:1 and monitor to ensure needs are met."

There was no documentation in the Social Services Notes addressing behavior modification interventions for Resident #32.

F 315 SS=D

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 "Tennessee CNA [Certified Nursing Assistant] Candidate Handbook, Version 4.5, Oct [October] 1, 2009", medical record review, observation and interview, it was determined the facility failed to ensure facility staff followed the Tennessee CNA standard of practice for perineal (peri) care or Foley catheter care for 1
**F 315** Continued From page 19

of 5 (Resident #11) sampled residents receiving peri-Foley care.

The findings included:

Review of the "Tennessee CNA Candidate Handbook, Version 4.5 Oct 1, 2009 documented "...Skill 7 ...10. Holds catheter near the urethra to prevent tugging on catheter and cleans 3- [to] 4 inches from the urethra down the drainage tube... 14. Does not allow the tube to be pulled at any time during the procedure... Skill 20 ...12. Using water and soapy washcloth, cleans one side of labia from top to bottom using a clean portion of a washcloth with each stroke. 13. Cleans other side of labia from top to bottom using clean portion of washcloth with each stroke. 14. Cleans vaginal area from top to bottom using clean portion of washcloth with each stroke..."

Medical record review for Resident #11 documented an admission date of 7/13/04 with diagnosis of Hypertension, Diabetes Mellitus, Congestive Heart Failure, Acute Renal Failure, History of Urinary Tract Infections and Urinary Retention. Review of the 6/4/10 physician's order documented "...Catheter care every shift and as needed..."

Observations in Resident #11's room on 5/25/10 beginning at 4:05 PM, CNA #1 performed peri care and Foley care. CNA #1 cleaned the left groin area down toward the bed four times, cleaned the right groin area down toward the bed four times alternating left and right sides. CNA #1 stated "...gotta rinse 'ya [you] off..." CNA #1 rinsed the left groin area then right groin area with a wet cloth twice for each side. CNA #1 stated "...gonna dry you off..." and dried the left then the right groin..."
Continued From page 20
area. CNA #1 stated "...gotta clean the middle..."
CNA #1 cleaned the vaginal area from top to
to bottom then cleaned down the catheter
approximately 4 inches two different times,
catheter tubing was pulled taut and CNA #1
asked Resident #11 "...does that hurt, honey?..."
CNA #1 did not clean the catheter without tugging
on it and failed to use a clean portion of the
washcloth each time.

During an interview in Resident #11's room on
5/25/10 during the above observation CNA #1
stated, "...gotta make sure she is clean so she
won't get any infection..."

**F 322**
**SS=D**

483.25(g)(2) NG TREATMENT/SERVICES -
RESTORE EATING SKILLS

Based on the comprehensive assessment of a
resident, the facility must ensure that a resident
who is fed by a naso-gastric or gastrostomy tube
receives the appropriate treatment and services
to prevent aspiration pneumonia, diarrhea,
vomiting, dehydration, metabolic abnormalities,
and nasal-pharyngeal ulcers and to restore, if
possible, normal eating skills.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation and
interview, it was determined the facility failed to
follow the physician's order for infusing the
Percutaneous Endoscopic Gastrostomy tube
feeding as ordered for 1 of 3 (Resident #14)
sampled residents with PEG tubes.

The findings included:

Medical record review for Resident #14
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 322</td>
<td>Continued From page 21</td>
<td>documented an admission date of 10/1/03 with diagnoses of Closed Head Injury due to Motor Vehicle Accident, Pelvic Fracture, Multiple Sacral Fracture, Quadriplegia, Dysphagia, and Paralysis. A physician's order dated 5/24/10 documented &quot;May hang Jejuni 1.5 cal [calorie] @ [at] 50cc [cubic centimeters] / [per] hr [hour] c [with] 25 cc auto flush x 1 [for] 15 hours @ 6 PM and remove at 9 AM in the morning x 1 then resume current schedule of 5 PM on &amp; [and] 8 AM off.&quot; Observations in Resident #14's room on 5/25/10 at 7:45 AM, revealed Resident #14 lying in the bed with no tube feeding infusing and an empty feeding tube bag in the trash can. During an interview in Resident #14's room on 5/25/10 at 12:10 PM, Nurse #5 stated, &quot;... [feeding] went off at 8 AM...&quot;</td>
</tr>
<tr>
<td>F 322</td>
<td>Continued from page 22</td>
<td>Corrective Action 1. An occurrence report was completed and the physician was notified on 5/28/10 of the error made in stopping the PEG feeding early for resident #11 on 5/25/10. No new orders received. 2. Individual in-service education was provided for Nurse #5 by the DON on 5/28/10 regarding following physician orders related to the time and amount of PEG tube feeding to be infused. 3. The licensed nurses were provided in-service education on 5/28/10, 5/29/10, 5/30/10, 5/31/10, 6/4/10 and 6/7/10 by the Administrator, ADON, SDC and RM regarding following physician orders related to the time and amount of PEG tube feeding to be infused. 4. An audit of PEG feedings by physician order was performed by nurse management on 5/28/10. 5. The DON, ADON and nurse management will monitor for compliance during daily observation rounds and report findings to the QA&amp;A Committee quarterly.</td>
</tr>
<tr>
<td>F 323</td>
<td>483.25(h) FREE OF ACCIDENT HAZARDS/SUPervision/DEVICES</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. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, it was determined the facility failed to ensure resident safety by not implementing new interventions after fails to prevent future falls for 3 of 15 (Residents #1, 20, and 33) sampled residents with multiple falls and by not</td>
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<td>ID</td>
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<td>Description</td>
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<td>F 323</td>
<td>Continued From page 22</td>
<td>maintaining security of the building due to a exit door being unlocked for 3 of 4 (5/24/10, 5/25/10 and 5/26/10) days of the survey. The findings included: 1. Medical record review for Resident #1 documented an admission date of 3/30/07 with diagnoses of Incipient Pacing, Multiple Falls, Hypertension, Hyperlipidemia, Congestive Obstructive Pulmonary Disease, Dementia and Osteoarthritis. Review of the Minimum Data Set (MDS) dated 3/24/10 for Resident #1 documented the resident had short term and long term memory problems and moderately impaired decision making. She was also assessed as needing extensive assistance with transfers, activities of daily living and ambulation. Review of the care plan dated 7/6/08 to present documented, &quot;Problem / Strengths... Risk for falls due to unsteady gait and t/o [history of] fracture&quot; 20 falls (16 in last 3 months).&quot; The care plan also documented the resident had falls on 1/19/10, 2/2/10, 2/4/10, 2/14/10, 2/17/10, 3/8/10, 3/23/10, 4/4/10, 4/11/10, 4/23/10, 5/15/10, 5/23/10, and 6/28/10. The intervention on 1/19/10, 2/3/10, 2/4/10, 2/14/10, 2/17/10, 3/8/10, 3/23/10, 4/4/10, 4/11/10, 4/23/10, 5/15/10, 5/23/10, and 6/28/10 was for &quot;Therapy to screen.&quot; Review of &quot;Nurse's Event Note&quot; documented the following: a. 4/4/10 at 3:50 PM &quot;...called to pt's [patient's] room by another pt who heard pt fall. Pt. was laying on floor with [s] head by the door... foot rest on the recliner was up. Pt has hematoma to top R [right] side of head. Neurochecks started. Pt. is not to be left in recliner c it reclined s [without] a</td>
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Continued from page 23

F 323

CNA [Certified Nursing Assistant] present. There was no intervention implemented to prevent future falls.
b. 5/15/10 documented, "fall, obtained skin tear to left arm, bruising to left shoulder and laceration above left eye, neurochecks initiated, pt sent to ER [emergency room] and admitted for observation." Entry to the care plan dated 5/16/10 documented, "Returned from hospital with sutures to left temp c new orders to remove sutures in 10 days."


There was no documentation of interventions implemented to prevent future falls.

2. Medical record review for Resident #20 documented an admission date of 3/10/10 with diagnoses of Hypertension, Depression, Anxiety, Gastroesophageal Reflux, Osteoarthritis, Diverticulitis, Dementia, and Cellulitis. Review of the MDS dated 3/22/10 and 5/19/10 documented Resident #20 had short term memory problems and was moderately impaired in decision making. MDS dated 3/22/10 documented extensive assistance with transfers, activities of daily living, and limited assistance with ambulation. Review of the "Nurses Event Note" dated 4/10/10 documented a fall with an intervention of therapy to screen with no new interventions implemented to prevent future falls.

3. Medical record review for Resident #33 documented an admission date of 3/13/02 with
<table>
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<tr>
<th>F 323</th>
<th>Continued From page 24</th>
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<tbody>
<tr>
<td></td>
<td>diagnoses of Mental Illness, Depression, Schizophrenia, Cerebrovascular Accident, Hypertension, Diabetes Mellitus, Coronary Artery Disease, and Osteoporosis.</td>
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<td></td>
<td>Review of Resident #33's care plan developed 12/14/09 and revised 3/9/10 documented the following falls and interventions:</td>
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<tr>
<td></td>
<td>a. 12/18/09 - watch closely to provide needs.</td>
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<td>b. 1/13/10 - therapy to screen with no new recommendations.</td>
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<td>c. 2/4/10 - monitor blood pressure for 3 days, therapy to screen with no new recommendations.</td>
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<td>d. 2/6/10 - therapy to screen with no new recommendations.</td>
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<td></td>
<td>e. 3/31/10 - therapy to screen with no new recommendations.</td>
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<td></td>
<td>f. 4/7/10 - therapy to screen with no new recommendations.</td>
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<tr>
<td></td>
<td>g. 6/10/10 - remind to call for assistance.</td>
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<td>There were no new interventions put in place after each fall to prevent future falls.</td>
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<td>During an Interview in the fine dining room on 5/26/10 at 10:00 AM, the Assistant Director of Nursing stated, &quot;...[the falling star program is for residents who] have had 3 falls within 90 days or score 20 or more on the Fall Risk Assessment, we put a star on the door...do not have a written fall prevention program...the nurses check these residents more frequently...&quot;</td>
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<td>During an interview in the therapy office on 5/26/10 at 12:55 PM, the physical therapist stated, &quot;...if [I] agree with the nursing interventions, then [I] don't always chart anything in recommendations...&quot;</td>
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</tbody>
</table>
Continued From page 25
During an Interview in the fine dining room on 5/26/10 at 3:55 PM, Nurse #10 stated, "...[there is] no falls protocol per say..." Nurse #10 was asked how did new staff know what to do for residents with the star on the door. Nurse #10 stated, "...[I] don't know-they should all know...

During an interview in the fine dining room on 5/26/10 at 4:00 PM, the physical therapist confirmed if she agreed with nursing interventions there was not always chart documentation from therapy.

During an interview in the fine dining room on 5/26/10 at 5:00 PM, the Director of Nursing (DON) was asked what qualified a resident to get a star of the door. The DON stated, "...probably weakness, history of falls, or assistive devices..."

During an interview in the fine dining room on 5/26/10 at 6:05 PM, the Administrator stated, "...we started [working with falls] back in March [2010]..."

4. Observations on 5/24/10 at 2:00 PM and 5:45 PM, on 5/25/10 at 3:00 AM, 11:45 AM, 3:00 PM, and 6:00 PM and on 5/26/10 at 7:00 AM, 1:30 PM, and 7:00 PM, revealed there was no gate on the courtyard fence which would prevent entrance and there was no lock on the door to prevent entrance to the building from the courtyard/smoke area.

During an interview in the conference room on 5/26/10 at 7:00 PM, the Administrator stated, "...the front door is unlocked until night time...there is no way to get in [the building] from the outside..." The Administrator was asked about the gate being off the fence. The Administrator...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/ SUPPLIER/CUA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION A. BUILDING</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
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<tbody>
<tr>
<td>445430</td>
<td>A. WING</td>
<td>05/27/2010</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**
LEWIS COUNTY MANOR

**STREET ADDRESS, CITY, STATE, ZIP CODE**
119 KITRELL ST, PO BOX 128
HOHENWALD, TN 38462

<table>
<thead>
<tr>
<th>(X4) ID. PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISO IDENTIFYING INFORMATION)</th>
<th>ID. PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 323</td>
<td>Continued From page 26 stated, &quot;...oh yeah, we removed it on Monday when Fire Safety was here cause [because] of fire hazard... no lock on the door to enter the breakroom... but that can be fixed quickly...&quot;</td>
<td>F 323</td>
<td></td>
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<td>F 332</td>
<td>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</td>
<td>F 332</td>
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<tr>
<td>SS=D</td>
<td>The facility must ensure that it is free of medication error rates of five percent or greater.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on policy review, medical record review, observation, and interview, it was determined the facility failed to ensure 2 of 8 medication nurses (Nurses #4 and 7) administered medications with a medication error rate of less than 5 percent (%). A total of 4 medication errors were observed out of 53 opportunities for error, resulting in a medication error rate of 7.54%.</td>
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<td>The findings included:</td>
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<td>1. Review of the facility's &quot;Enteral Feedings&quot; policy documented, &quot;...Guidelines... Crush pill (if crushable), and mix with fluid to make a thin solution with small sediment...&quot;</td>
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<td>2. Medical record review for Resident #3, documented an admission date of 8/22/02 with diagnoses of Cerebral Palsy, Mental Retardation, Hematemesis, Seizure Disorder, Gastrointestinal (GI) Bleed, Chest Pain, Gastritis, Psoasitis/Like Disorders, Urinary Retention, Hematuria, Constipation, Methicillin-Resistant Staphylococcus Aureus (MRSA) of Abdominal and Nares and the Left Eye. Review of a physician's</td>
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</table>

**F332**

483.25(m)(1)
FREE OF MEDICATION ERROR RATES OF 5% OR MORE
SS=D
Requirement
The facility will ensure it is free of medication error rates of five percent or greater.

**Corrective Action**
1. Individual in-service education was provided to Nurse #4 on 5/28/10 by the DON regarding medication administration with a PEG tube and return demonstration of competency with skill.
2. Individual in-service education was provided to Nurse #7 regarding medication administration by the DON on 5/27/10.
3. A medication occurrence was completed on 5/25/10 by the DON regarding the error with resident #32 with physician and family notification of error.
4. Licensed nurses were provided in-service education regarding medication administration and medication administration with a PEG tube on 5/28/10, 5/29/10, 5/30/10, 5/31/10, 6/4/10 and 6/11/10 by the Administrator, ADON, SDC and RM.

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F 332

[Percutaneous Endoscopic Gastrostomy] BID [two times a day] X [times] 14 days P/V [related to] MRSA to abdomen, Bactrim DS [Double Strength] 1 tab. per peg BID X 4 weeks."

Observations in Resident #3’s room on 5/25/10 beginning at 9:08 AM, revealed Nurse #4 crushed Hydrocodone/Acetaminophen (APAP) 5-500 mg 1 tab, Amoxicillin/Clavulanate Potassium 500 mg/250 mg, and Sulfamethoxazole/Trimethoprim 800 mg/160 mg 1 tab, and mixed them together. After flushing the PEG tube with water Nurse #4 administered the medication and then threw the cup away. Nurse #4 retrieved the cup from the garbage. The surveyor observed a thin film of white residue on the inside of the medication cup. Resident #3 did not receive all of the medications which resulted in errors #1, 2, and 3.

During an interview in Resident #3's room on 5/25/10 at 9:16 AM, Nurse #4 was asked about the amount of medication remaining in the cup. Nurse #4 stated, "Just a little."

3. Medical record review for Resident #32 documented an admission date of 8/4/08 with diagnoses Bipolar, Chronic Obstructive Pulmonary Disease, Schizophrenia, Arthritis/Osteoarthritis, Hypothyroidism, Gastrointestinal Reflux Disease, Hypertension, Cardiovascular Accident, Dementia, Rheumatoid Arthritis, Depression, Seizure Disorder, Acute Renal Failure, and Dehydration. A physician's order signed 5/19/10 documented, "Calcium
LEWIS COUNTY MANOR  

<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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</table>
| F332 | Continued From page 28  
Carbonate 500 mg po [by mouth] bid.  
Observations in Resident #32's room on 5/25/10 at 4:38 PM, revealed Nurse #7 administered Calcium with Vitamin D 500 mg. The failure to administer Calcium Carbonate 500 mg resulted in medication error #4. During an interview in the front lobby of the facility on 5/25/10 at 9:00 AM, the Director of Nursing (DON) stated, "I see that wasn't the correct medication." During an interview in the fine dining room across from the back hall's chart room on 5/26/10 at 4:10 PM, the DON stated "Yes, I knew about that error [Calcium with Vitamin D being administered instead of the ordered Calcium Carbonate]." | F332 |  |

| F406 | PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES  
If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by:  
Based on medical record review and interview, it was determined the facility failed to ensure mental health rehabilitation services addressed behavioral symptoms for 5 of 33 (Residents #1, | F406 |  
483.45(a)  
PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES  
SS=D  
Requirement  
The facility will provide the required specialized mental health rehab services for behavioral symptoms.  
Corrective Action  
1. Resident #1, #12, #29, #31 and #32 medical record reviewed on 5/27/10 and 6/7/10 by Administrator, ADON, SS and AD for behavioral symptoms with new interventions developed and implemented if needed.  
Continued on page 30 |
### Continued from page 29 F406

12, 29, 31 and 32) sampled residents.

The findings included:

1. Medical record review for Resident #1 documented an admission date of 3/30/07, last readmission date of 5/16/10 with diagnoses of Incessant Pacing, Multiple Falls, Hypertension, Chronic Obstructive Pulmonary Disease, Dementia and Osteoarthritis. Review of Minimum Data Set (MDS) dated 3/24/10 for Resident #1 documented the resident had short term and long term memory problems and moderately impaired decision making.

Review of the care plan dated 7/6/09 to present documented, "PROBLEMS / STRENGTHS... Episodes of mood as demonstrated by: face and anxiety disorder not easily redirected..." An entry to the care plan dated 3/23/10 documented, "PROBLEM: Patient wanders, fidgets and anxious... GOALS: Staff will continue to monitor for episodes of mood and provide interventions as indicated and ordered." with interventions to "Provide Aroma Therapy, sound stimuli, quiet area with few distractions."

Review of the care plan for "Episodes of: socially inappropriate behavior as demonstrated by: increased agitation, physically aggressive behavior and yelling out." and updated on the following dates documented the following:

a. 1/13/10 "...noted to be pacing halls on this day & [and] stepped another patient [pt] on left upper arm..."

b. 1/15/10 "...physical altercation with another patient..."

c. 1/21/10 "...physical altercation with another patient. This patient hit patient in another room..."
F 406 Continued From page 30
right forearm...
d. 1/24/10 "...combative during care causing a
    skin tear..."
e. 2/19/10 "...wandered into another patient's
    room, physical altercation between these two
    patients..."
f. 2/22/10 "...physical altercation with another
    patient..."
g. 3/2/10 "...wandered into another patient's room
    & was rummaging through belongings. The other
    pt told this pt to leave & this pt hit other pt on
    arm..."
h. 3/25/10 "...wandered into another pt's room,
    physical altercation between pts, other pt's
    grabbed this pt's arm & this pt slapped other pt..."
i. 4/5/10 "...physical altercation with another pt.
    This pt was in another pt's room taking stuff &
    other pt attempted to stop pt & this pt slapped
    other pt's right arm...
j. 5/5/10 "...This pt hit another pt in chest...
k. 5/11/10 "...This pt wandered into another pt's
    room, other pt hit this patient in the back..."

The interventions for these behaviors documented on 1/13/10, 1/15/10, 2/19/10,
2/22/10, 3/25/10, 5/5/10, and 5/11/10 were to redirect the resident and continue to monitor.
There was no behavior management put in place for this resident.

2. Medical record review for Resident #12 documented an admission date of 8/4/09 with
diagnoses of Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Hypertension, Urinary
Incontinence, Dementia, and Depression.

Review of the care plan dated 8/13/09 to present
documented the following:
a. Wandering from 8/13/09 to present
| F 406 Continued From page 31 |
|---------------------------------
| "Interventions... Monitor resident location with visual checks every shift. Visually check antivander guard bracelet to ankle every shift..."
| b. Entry dated 1/7/10 "Monitor frequently of patient whereabouts and placement of wanderguard bracelet. This was reviewed by staff through 4/27/10. "Problems / Strengths: Episodes of socially inappropriate behavior demonstrated by: rummaging through others belongings. Interventions: Encourage activities of residents choice and preference, Keep MD [Medical Doctor] aware of changes or problems."
| c. Entry dated 6/25/10 "Encourage participation in Grandma's Attic Program."
| Review of Advanced Psychiatric Services, Mental Health Progress Note, documented "Observed Clinical Response: Pt. lying on bed, alert, verbal, recall poor at x's, pt. talked about hx [history] of migrans. pt. denied other problems. Mood improved more with talk. O [no] behaviors noted. Recommendations: Reorient/ Reassure pt. pm [as needed]." Resident was seen again on 4/17/10 and on 4/24/10 "Suggest d/c [discontinue] counseling sessions indefinitely due to pts limited ability to engage in tx [treatment]. Monitor emotional status ongoing..." There was no behavioral management put in place for this resident.
| 3. Medical record review for Resident #29 documented an admission date of 12/1/09 with diagnoses of Diabetes, Rheumatoid Arthritis, Seizures, and Dementia. Review of Recertification Physician's orders dated 12/1/09, 1/7/10, and 4/1/10 documented, "MENTAL HEALTH TO EVAL [evaluate] AND TREAT AS INDICATED."
CONTINUED FROM PAGE 32

Review of the nurse's notes documented the following:

a. 12/2/09 at 8:00 PM, "Pt demanding Lortab, states he took it every 2 hours [hours] at home. Pt states, "I am leaving here."

b. 12/2/09 at 8:15 PM, "Pt dressed to leave, crying, states he is depressed because his daughter killed herself a year ago...

c. 12/4/09 at 9:00 PM, "...pt states he is leaving her tomorrow if we do not help him..."

d. 12/7/09 at 4:35 AM, "...pt states to CNA [Certified Nurse Assistant] if nurse did not give him his pain med now, he would come and get it; when informed pain medication is not due yet pt replied, 'that's bull...[cursed word] I'm walking up and down the hallway at this time.'"

e. 12/12/09 at 6:50 PM, "Pt crying with daughter at this time..."

f. 12/20/09 at 11:00 PM, "Pt immediately started to curse and stated, 'Don't tell me that G... [curse word] It, I know it is time for my pill..."

g. 12/27/09 at 2:00 AM, "Pt very agitated and cursed at CNA assigned to hall..."

h. 1/1/10 at 1:30 PM, "Pt outside in front of facility smoking... had cigarette and lighter in his room..."

i. 1/31/10 at 1:50 AM, "Pt requested a sandwich and milk, became agitated when CNA could not assist him until after vital signs. Pt became more agitated and began cursing and walked back to room cursing the whole way..."

j. 2/16/10 at 3:15 PM, "...When CNA told pt she wasn't allowed in the kitchen to cook chicken strips, pt began cursing CNA..."

k. 3/1/10 at 12:15 PM, "...Pt became agitated and raised his voice and cursing because pain med could not be given at this time..."

l. 3/1/10 at 12:15 PM, "...Reported by CNA that pt demanded cigarettes from other resident's supply..."
Continued From page 33

and began to curse CNA...

m. 3/2/10 at 9:00 PM, "...Pt stated he does not have anything to live for, I can't get the help I need and I feel pretty bad about it. Pt crying..."

n. 4/10/10 at 2:00 AM, "...Pt at desk demanding to smoke, when told no, pt cursed writer stating "F...[curse word] B...[curse word]..."

o. 4/20/10 at 5:15 PM, "...Pt became upset because pain medication was 15 minutes late, resident started yelling and cursing, stating, "Stupid B...[curse word], I know now why your old man beat you up, he should of killed you, I know all about you, you fat lazy b..."

p. 5/14/10 at 4:00 AM, "...Pt at desk cursing..."

q. 5/24/10 at 7:45 PM, "...Pt trying to leave facility, very agitated, cursing...

There was no documentation that psychiatric services had been ordered nor were interventions implemented for the behaviors exhibited in a timely manner.

During an interview in the fine fining room on 6/27/10 at 10:00 AM, the Administrator stated, "The social worker is able to get mental health services started."

During an interview in the Social Worker's (SW) office on 5/27/10 at 10:25 AM, the SW stated, "I don't know why mental health services were not started any earlier than 5/6/10, the nurses should of done that."

4. Medical record review for Resident #31 documented an admission date of 5/10/2008 with diagnoses of Vascular Dementia with Behavioral Disturbance, Mood Disorder, Non-Insulin Dependent Diabetes Mellitus, Glaucerna, Gastrointestinal Reflux Disease, Hypothyroidism,
F 406 Continued From page 34

Hyperlipidemia and Dementia with Behavioral Disturbance.

Review of the nurse’s notes documented the following:
- a. 4/1/10 at 2:10 PM, "Refused to have vital signs taken by staff..."
- b. 4/6/10 at 6:50 PM, "VS [vital signs] are refused. Pt had 2 altercations... Pt separated from other residents involved..."
- c. 4/7/10 at 5:30 PM, "VS were refused this shift..."

Review of the MDS dated 4/2/10 documented Resident #31 had short and long-term memory loss and was moderately impaired in decision making.

Review of the care plan dated 4/2/10 to present documented the following:
- a. 4/2/10 "Risk for side effects from psychotropic medication use... Interventions... Patient picks and pokes at staff + other patients + laughs and resists care"
- b. 4/6/10 "p) [problem] physical altercation with another patient + caused a skin tear to other patient... Goals Staff will monitor behavior + provide interventions as indicated when exhibiting physically aggressive behavior. The only interventions "Cont [continue] to monitor for physically aggressive behavior + redirect + separate as needed... Cont to monitor redirect when exhibiting physically aggressive behavior. Provide diversional activities."
- c. 5/13/10 "p) staff want to assist patient to her room, became agitated + proceeded to sit down in the floor with CNA assistance. Pt then proceeded to lie back CNA's X [times] 3 + Nurses X 2 assisted patient out of floor."
There were no new interventions implemented to address the wandering and physically aggressive behaviors.

During an interview in Resident #28's room on 5/28/10 at 9:00 PM, Resident #28 stated, "[Resident #31] has gotten in bed with me and roommate. Has hit me. I reported this. More than once... Once nurse saw this happen."

During this interview in RR #26's room on 5/28/10 at 9:00 PM, Resident #31 came to RR #28's room and turned on the light and then came into the room. Both RR #26 and roommate had to tell Resident #31 to get out of their room.

5. Medical record review for Resident #32 documented an admission date of 8/4/09 with diagnoses of Osteoporosis, Head Injury, History of Fracture Ribs, Hypertension, Alcohol Dependency, Chronic Obstructive Lung Disease, History of Lung Cancer, Dementia with Psychosis, Diabetes Mellitus, Bipolar Affective Disorder, Schizophrenia, Osteoarthritis, Depression, Gastroesophageal Reflux Disease, Cerebrovascular Accident, Seizure Disorder, and Acute Renal Failure. Review of the MDS dated 4/29/10 documented Resident #32 exhibited persistent anger with self or others for up to 5 days a week, and socially inappropriate / disruptive behavioral symptoms 1 to 3 days in the last 7 days of the assessment period.

Review of the nurses notes documented the following:

a. 3/1/10 at 7:00 PM, "...Pt is agitated. Wanted to go to smoke 30 mins [minutes] earlier when redirected got ill. Will cont to monitor."
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Lewis County Manor  
**Street Address, City, State, Zip Code:** 119 Kittrell St, PO Box 129, Hohenwald, TN 38462

<table>
<thead>
<tr>
<th>Deficiency</th>
<th>Description</th>
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| F 406      | Continued from page 36  
  b. 4/13/10 at 1:00 AM, "Patient was very loudly yelling, being rude, cursing at staff she thought it was that to eat, we gave a sandwich and cup of juice, she finally went to sleep."  
  c. 5/20/10 at 9:00 AM, "pt yelling at this writer about her medications patient stated 'you did not give me my ... [curse word] medications' attempted to explain to patient that she had received her 9 am meds [medications] and another staff member witnessed it as well. pt remained agitated..." |

Review of the care plan dated 8/17/09 to present documented the following:  
  a. 1/10/10 "p) Refused incontinence care or bath, physically aggressive towards staff & verbally aggressive, pt left alone."  
  b. 1/4/10 "p) overheard by staff telling roommate she was going to hurt her, 1: [on] 1 provided & pt states she wouldn't do that as she loves her roommate."  
  c. 2/4/10 "p) cont to be verbally aggressive towards staff cont. frequent meal and medication refusal" and documented an intervention of "staff to cont to monitor behavior & keep MD aware."  
  d. 5/20/10 "p) yelling at nurse stating she didn't get her medicine reassured "pt" and documented an intervention of "Provide reassurance & reminding regarding medication as needed."  

There were no new interventions implemented to address the verbally abusive and physically aggressive behaviors.

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<tr>
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<tr>
<td>F 431</td>
<td>483.60(b), (d), (e) Drug Records, Label/Store Drugs &amp; Biologicals</td>
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The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all
**NAME OF PROVIDER OR SUPPLIER**
LEWIS COUNTY MANOR

**STREET ADDRESS, CITY, STATE, ZIP CODE**
119 KITTLER ST, PO BOX 129
HOHENWALD, TN 38462

**DATE SURVEY COMPLETED**
05/27/2010

<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>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 431</td>
<td>Continued From page 37 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. 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 1 of 8 (Nurse #5) medication nurses failed to ensure medications were stored in locked compartments at all times. The findings included:</td>
<td>F 431</td>
<td>483.60(b),(d),(e) DRUG RECORDS, LABEL/STORE DRUGS AND BIOLOGICALS SS-D Requirement The facility will ensure medications are stored in a locked compartment and permit only authorized personnel to have access. Corrective Action 1. In-service education was provided to Nurse #5 on 5/28/10 by the DON regarding medication not in locked compartment is to only have authorized personnel with access. 2. Licensed nurses were provided in-service education on 5/28/10, 5/29/10, 5/30/10, 5/31/10, 6/4/10 and 6/7/10 regarding medication not in locked compartment is to have only authorized personnel with access. 3. Medication administration audit to be performed by the DON, ADON and nurse management on each licensed nurse 6/4/10 to 6/15/10 with a focus on storage and access of medications. 4. The DON, ADON and nurse management will monitor for compliance during daily observation rounds and report findings to the QA&amp;A Committee quarterly.</td>
<td>6/15/10</td>
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<td>F 431</td>
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<td>F 441</td>
<td>Observation in Resident #14's room on 6/25/10 at 12:05 AM, revealed Nurse #5 placed Resident #14's medications in a cup for on the bedside table asking a technician (tech) to watch them. Nurse #5 walked out of the room leaving the medications out of her view. During an Interview in the fine dining room on 5/26/10 at 5:20 PM, the Director of Nursing was asked about nurses leaving a technician to watch medication. The DON stated, &quot;Certainly not let a tech watch medications.&quot;</td>
<td>F 441</td>
<td>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</td>
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<td>SS=E</td>
<td>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</td>
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<td>The facility will maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to hold prevent the development and transmission of disease and infection. Corrective Action I. Individual in-service education was provided to Nurse #1, #4, #5, #6 and #7 on 6/4/10 by the Administrator regarding infection control practices during medication pass to prevent cross contamination; ie cleaning of resident care equipment, proper handling of eye drop container, inhaler and gloves, sanitary protection of the PEG tube.</td>
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F.441  Continued from page 39
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
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 policy review and observations, it was
determined the facility failed to ensure 5 of 8
(Nurses #1, 4, 5, 6 and 7) medication nurses
observed during the medication administration
pass maintained infection control practices to
prevent the possibility of cross-contamination by
not cleaning resident care equipment; improper
handing of eye drop container, inhaler and
gloves, and the sanitary protection of the
Percutaneous Endoscopic Gastrostomy (PEG)
tube.

The findings included:

1. Review of the facility’s infection control policy
documented “...cleaning and sanitizing of
equipment... exercising care to prevent cross
contamination when providing personal care...”

2. Observations in Resident #1’s room on
5/24/10 at 5:12 PM, revealed Nurse #1 placed
Combivent inhaler in his uniform pocket.
<table>
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<td>Observations in Resident #1's room on 5/24/10 at 5:24 PM, revealed Nurse #1 placed Ventolin inhaler in his uniform pocket.</td>
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<tr>
<td>3. Observations in Resident #3's room on 5/25/10 at 9:35 AM, revealed Nurse #4 placed the bottle of Gentamycin eye drops on the shelf in Resident #3's bathroom (shared bathroom with another resident) without a barrier under the eye drop bottle. Resident #3 was in isolation for Methicillin-Resistant Staphylococcus Aureus of the left eye, nares and abdomen.</td>
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<td>4. Observations in Resident #14's room on 5/25/10 at 12:10 PM, revealed Nurse #5 did not clean the stethoscope before or after assessing the feeding tube placement.</td>
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<td>5. Observations in Random Resident (RR) #4's room on 5/25/10 beginning at 12:45 PM, Nurse #6 placed a bottle of Artificial tears on the bathroom sink without a barrier. At 12:46 PM, Nurse #6 removed the bottle of Artificial tears from the sink and placed the bottle of Artificial tears on the back of the commode without a barrier while she picked paper towels up off the floor. At 12:47 PM, Nurse #6 removed a box of gloves from RR #6's over bed table and left the room. Nurse #6 placed the box of gloves on the medication cart outside of RR #4's room.</td>
</tr>
<tr>
<td>6. Observations in Resident #32's room on 5/25/10 at 5:07 PM, revealed Nurse #7 did not clean the blood pressure and oxygen saturation machines after use on Resident #32's room. The blood pressure cuff and oxygen saturation machine were then placed in Nurse #7's uniform pocket.</td>
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<tr>
<th>F 469 MAINTAINS EFFECTIVE PEST</th>
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CONTROL PROGRAM

The facility must maintain an effective pest control program so that the facility is free of pests and rodents.

This REQUIREMENT is not met as evidenced by:

Based on observations, it was determined the facility failed to ensure the environment was free of flies in 6 of 68 (resident rooms 102, 104, 105, 202, 502 and 507) resident rooms and 2 of 5 (100 and 400) halls.

The findings included:

1. Observations in resident room 102 on 5/24/10 at 11:05 AM, revealed flies, flying around the resident and landing on the bed and bedside table.

2. Observations in resident room 104 on 5/24/10 at 10:50 AM, revealed flies, flying around a sleeping resident.

3. Observations in resident room 105 on 5/24/10 at 10:40 AM, revealed flies, flying around a resident.


5. Observations in resident room 502 on 5/28/10 at 12:40 PM, revealed a fly, flying around

Correction Action
1. Patient areas were examined for food not in concealed container on 5/24/10.
2. Equipment supplied to staff for fly elimination on 5/25/10.
3. Fly detractors were placed at the entrance/exit doorways on 5/25/10.
5. In-service education with the staff on 3/25/10, 6/4/10 and 6/7/10 by the Administrator regarding entrance/exit doors not to be open a prolonged period of time.
6. The Administrator and maintenance personnel will monitor for compliance during daily observation rounds and report the findings to the QA&A Committee.

COMPLETION DATE 6/7/10
Continued from page 42

Resident #26’s bed.

6. Observations in resident room 507 on 5/24/10 at 10:07 AM, revealed a fly on Resident #26’s forehead.

7. Observations in the 100 hall on 5/24/10 at 11:00 AM and on 5/25/10 at 1:15 PM, revealed the presence of flies.

8. Observations in the 400 hall on 5/25/10 at 8:05 AM, revealed the presence of flies.

F 469

F 502

483.75(k)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to obtain laboratory (lab) tests as ordered for 3 of 33 (Residents #3, 6 and 11) sampled residents.

The findings included:

1. Medical record review for Resident #3 documented an admission date of 8/22/02 with diagnoses of Methicillin Resistant Staphylococcus Aureus of the Left Eye, Cerebral Palsy, Seizure Disorder, Mental Retardation and Gastritis. Review of the current physician’s recertification orders documented "[date order first written] 9/17/06... DILANTIN LEVEL EVERY 3 MONTHS, PHENOBARBITAL LEVEL EVERY 3 MONTHS..."
Continued from page 43

There was no documentation the Dilantin and Phenobarbital levels were performed as ordered in January 2010.

During an interview in the fine dining room on 5/26/10 at 11:10 AM, the Assistant Director Of Nursing (ADON) confirmed the January 2010 Dilantin and Phenobarbital labs were missed.

2. Medical record review for Resident #5 documented an admission date of 4/30/09 with diagnoses of Dementia, Hypertension and Congestive Heart Failure. Review of a physician's telephone order dated 5/14/10 documented "COLLECT URINE, CBC [complete blood count] AND CMP [complete metabolic profile]." There was no documentation the urine, CBC and CMP lab tests were performed as ordered.

During an interview in the fine dining room on 5/26/10 at 11:10 AM, the ADON confirmed the urine, CBC and CMP lab tests were never obtained.

3. Medical record review for Resident #11 documented an admission date of 7/13/04 with diagnoses of Hypertension, Diabetes Mellitus, Anxiety, Coronary Artery Disease, Congestive Heart Failure, and Acute Renal Failure. A physician's order dated 4/26/10 documented "Recheck labs on Friday [4/30/10] - BNP [brain natriuretic peptide], CMP and CBC." Review of physician's recertification orders dated 6/4/10 documented "...date order first written 11/07/09. BMP [basic metabolic profile], CBC q [every] 6 months, HgbA1c [glycosylated hemoglobin] q every 3 mo [months]." There was no documentation the BNP, CMP, BMP, CBC HgbA1c lab tests were performed as ordered.
During an interview in the conference room on 5/25/10 beginning at 5:15 PM, the Director of Nursing (DON) was asked about the order for BMP and CBC q 6 months and the HgbA1C q 3 months. The DON stated, "...I wrote that [order] in when I reviewed the recent [recertification] orders for 5/4/10..." The ADON confirmed the lab [BNP, CMP, and CBC] was not done on 4/30/10. The Administrator stated, "...we received this order [dated 4/26/10] 5/14/10 in a package of papers that came from her [the physician's office]... It was discovered in chart audits on 5/19/10 and we immediately did it [the lab] then [5/19/10]...."