NAME OF PROVIDER OR SUPPLIER
LINCOLN DONALSON CARE CENTERS

STREET ADDRESS, CITY, STATE, ZIP CODE
501 AMANA AVENUE
FAYETTEVILLE, TN 37334

For Resident #5, the MD was notified on 3/10/10. No further intervention required.

All residents with a significant change including new complaints of pain after an incident with injury, or potential for injury, which may require physician intervention will be transported for appropriate treatment after notification of physician, legal representative, or interested family member. Any event of this nature, the incident report will be generated by the charge nurse and discussed in daily morning meeting with DON, ADON, Unit Manager, Unit Coordinator, Social Services, Dietary Manager and Administrator, with appropriate interventions initiated. The DON & ADON will review the incident reports for proper notification of MD, family, or legal representative, and appropriate follow through. A PI study will be implemented and carried out for 90 days to reveal statistics for completion of incident reports to include notification of MD, family, and/or legal representative beginning July 30, 2010. Information gained will be discussed at monthly PI meeting.

RECEIVED
JUL 20 2010

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 discloseable 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 discloseable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
**Summary Statement of Deficiencies**

(F9) ID  
PREFIX TAG  
POISON'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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<th>ID</th>
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<td>F157</td>
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Continued from page 1

complaint of pain and evidence of swelling of the right ankle for 1 of 31 (Resident #5) sampled residents.

The findings included:

Medical record review for Resident #5 documented an admission date of 12/15/09 with diagnoses of Congestive Heart Failure, Gastric Esophageal Reflux Disease, Peripheral Vascular Disease, Chronic Obstructive Pulmonary Disease, Chronic Renal Failure, Insulin Dependent Diabetes Mellitus, and Atrial Fibrillation. Review of a Nurse's Note dated 3/5/10 documented, "tells of soreness to rt [right] outer ankle after she admits to hitting the ankle on table at Dr.'s [Doctor's] office yesterday while stepping up on step to table..." Review of Nurse's Note dated 3/6/10 documented, "resident c/o [complains of] R [right] ankle pain. Appears to be swollen, bruised around ankle bone area. Ice pack applied for comfort." Nurse's Note dated 3/7/10 documented, "Resident @ [at] ankle continues to be swollen. Resident walks with limp. Continues to have ice pack on it." A Nurse's Note dated 3/10/10 documented, "Resident continues to c/o R ankle discomfort call to [medical doctor's name] to request x-ray." Nurse's Note dated 3/16/10 documented, "Resident to see [orthopedic physician's name] today for nondisplaced fx [fracture] of rt lateral malleolus, & [and] osteoporosis..." There was no documentation in the medical record from 3/5/10 through 3/9/10 that the physician had been notified of the resident's physical status change.

During an interview in the skilled hall nurses station on 6/30/10 at 7:25 AM, the Director of Nursing (DON) stated, "I don't see anything
**F 157**
Continued From page 2
[documentation of earlier physician notification]
else."

**F 161**
483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS

The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to ensure the surety bond was sufficient to protect the residents' funds for 2 of 3 (March 2010 and April 2010) months reviewed.

The findings included:

1. Record review of the facility's surety bond revealed the surety bond amount was $50,000.00.

2. Review of the facility's resident trust fund bank records for March 2010 documented an ending balance of $1,830.09, a balance of $1,830.09 which was in excess of the $50,000.00 surety bond.

3. Review of the facility's resident trust fund bank records for April 2010 documented an ending balance of $51,919.79 a balance of $1,919.79 which was in excess of the $50,000.00 surety bond.

4. During an interview in the hall at the front entrance, on 6/30/10 at 1:15 PM, the

Bank statement showed $51,930.09 as balance on 3/31/10. Reconciliation shows an actual balance of $49,999.47. Copies are included for review.

Bank statement showed $51,919.79 for balance on 4/30/10. Reconciliation shows an actual balance of $46,993.81 on 4/30/10. Copies are included for review.

Administrator instructed Business Office Manager to increase Surety Bond to $60,000.00. This was done on June 30, 2010. Copies are included for review.

Administrator will review monthly bank statements to ensure that $60,000.00 is sufficient to meet resident bond requirements.
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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 161</td>
<td></td>
<td>Continued From page 3 Administrator stated, &quot;[Named staff member] said we went over 50,000, so I told her to just up it to 60,000...&quot;</td>
<td>F 161</td>
<td></td>
<td>For Resident #12, a grieving care plan was initiated with appropriate interventions. Social Services will visit and counsel resident with documentation weekly for 4 weeks, or on an as-needed basis. Psychologist will continue to follow resident and intervene as needed. Resident will be followed until grieving issues are resolved.</td>
<td>7/1/10</td>
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<tr>
<td>F 250</td>
<td></td>
<td>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.</td>
<td>F 250</td>
<td></td>
<td>Management team, which includes DON, ADON, Unit Managers, Unit Coordinators, Social Services, Activities, and Dietary, will identify and discuss possible grieving issues during daily stand up meetings. Social Services will counsel and document on grieving residents weekly for 4 weeks, or on an as-needed basis. Then 1 time per month for 3 months, then quarterly according to MDS/RAI schedule. Psychologist will be consulted on each grieving issue for interventions and recommendations.</td>
<td>7/1/10</td>
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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 grief for 1 of 31 (Resident #12) sampled residents.

The findings included:
Medical record review for Resident #12 documented an admission date of 2/15/08 with a readmission date of 5/15/10 with diagnoses of End Stage Renal Disease, Hypertension, Asthma, Depression, Arthritis, Left Hip Arthroplasty, Fall, and Chronic Obstructive Pulmonary Disease. Review of the Social Services Interdisciplinary Note dated 3/5/09 documented, "...She [Resident #12] has really enjoyed someone else taking the responsibility of her husbands care. He is dying and will provide emotional support and allow her to vent her feelings..." There was no further documentation in the Social Services Interdisciplinary Notes of any grief counseling or her husband's death.

See Addendum E
### F 250

Review of the Psychologist's Progress Notes dated 6/15/10 documented "Psychology... she [ Resident #12] welcomed the opportunity to talk and became tearful as she talked about her husband's death... she stated 'If I talk about my husband, I start crying.' She reports doing well 'most of the time' but described bouts of sadness and 'difficult days'..."

During an interview in Resident #12's room on 6/29/10 at 8:35 AM, Resident #12 stated her husband died in March of last year [2009] and she became tearful talking about him.

During a subsequent interview in Resident #12's room on 6/29/10 at 4:40 PM Resident #12 stated, "My husband died last March [2009], it is difficult to get over that, we were together a long time."

During an interview in the social worker's office on 6/29/10 at 5:00 PM, the Social Worker #1 stated, "I have talked with [named Resident #12] several times, I just failed to document it. I know I should have."

### F 309

**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING**

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

This **REQUIREMENT** is not met as evidenced by:
Based on medical record review, observations,
Continued From page 5

and interview, it was determined the facility failed to ensure staff followed physician’s order for thickened liquids and dietary supplements for 1 of 31 (Resident #15) sampled residents and Random Resident (RR #1) observed during medication administration.

The findings included:

1. Medical record review for Resident #15 documented an admission date of 11/6/07 with diagnoses of history of Falls, Alzheimer’s Disease, Osteoarthritis, Osteoporosis and Anxiety. Review of the physician’s orders dated 6/5/10 documented "...NECTAR THICK LIQUIDS [NTL]..."

Observations in Resident #15's room on 6/29/10 at 7:45 AM, revealed Nurse #2 administered Resident #15’s medications with 8 ounces of regular thin water.

During an interview outside room 61 on 6/30/10 at 9:30 AM, Nurse #2 was asked about the order for NTL. The surveyor and Nurse #2 reviewed the Medication Administration Record (MAR) and the order for NTL was not noted on the MAR. Nurse #2 stated, "...I gave it [medication] with 8 ounces of water... we probably need to make sure that [thickened liquids] gets put on the MAR..." Nurse #2 was asked if Resident #15 should have gotten the NTL with her medications. Nurse #2 stated, "...She [Resident #15] probably should have, I'm sorry..."

2. Medical record review for RR #1 documented an admission date of 2/6/10 with diagnoses of Hypertension, Congestive Heart Failure, Irritable Bowel Syndrome, Gastroesophageal Reflux
**NAME OF PROVIDER OR SUPPLIER**

**LINCOLN DONALSON CARE CENTERS**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

501 AMANA AVENUE
FAYETTEVILLE, TN 37334

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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 309</td>
<td>Continued From page 6</td>
<td>Disease, Renal Insufficiency, Anxiety, Depression, Osteoporosis, Osteoarthritis, Idiopathic Thrombocytopenia, and Mild Hypoglycemia. Review of the physician's recertification orders for June 2010, signed but not dated, documented &quot;...ENSURE PLUS 4oz [ounces] BID [two times a day] BETWEEN MEALS...&quot;</td>
<td>F 309</td>
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Observations outside RR #1's room on 6/29/10 at 8:02 AM, revealed Nurse #3 prepared RR #1's medications, poured approximately 4 oz of Ensure Plus into a cup, and then poured more than half of it back into the can. Nurse #3 went into RR #1's room and administered RR #1's medications, and then gave the cup of Ensure to RR #1. Nurse #3 stated, "...Here's your milk..." RR #1 had her breakfast tray on the overbed table, and was still eating her meal. RR #1 drank all of the Ensure, and then as Nurse #3 was leaving the room, RR #1 asked "Where's my milk?" Nurse #3 told RR #1, "You drank it all."

During an interview outside RR #1's room on 6/29/10 at 8:10 AM, Nurse #3 was asked how much Ensure RR #1 received. Nurse #3 stated, "...four ounces... she [RR #1] gets 8 ounces twice a day... no 4 ounces... she didn't get 4 ounces... it was about 2 ounces... sometimes she won't take it all..."

During an interview in Room 51 (survey team room) on 6/30/10 at 10:00 AM, the Director of Nursing (DON) was asked when a supplement should be given if it is ordered between meals. The DON stated, "...if breakfast is at 7 [o'clock] and lunch is at 11 [o'clock], I would think around 9:30 [AM] or 10:00 [AM]..." The DON was told that the nurse only offered RR #1 less than half of
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<td>F 309</td>
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<td>Continued From page 7 the Ensure that was ordered. The DON stated, &quot;...should give what is ordered...&quot;</td>
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<td>F 431</td>
<td>SS=D</td>
<td>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</td>
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<td>The facility must employ or obtain the services of a licensed pharmacist who establishes a system</td>
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<td>of records of receipt and disposition of all controlled drugs in sufficient detail to enable an</td>
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<td>accurate reconciliation; and determines that drug records are in order and that an account of all</td>
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<td>controlled drugs is maintained and periodically reconciled.</td>
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<td>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted</td>
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<td>professional principles, and include the appropriate accessory and cautionary instructions, and</td>
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<td>the expiration date when applicable.</td>
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<td>In accordance with State and Federal laws, the facility must store all drugs and biologicals in</td>
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<td>locked compartments under proper temperature controls, and permit only authorized personnel to</td>
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<td>have access to the keys.</td>
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<td>The facility must provide separately locked, permanently affixed compartments for storage of</td>
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<td>controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of</td>
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<td>1976 and other drugs subject to abuse, except when the facility uses single unit package drug</td>
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<td>distribution systems in which the quantity stored is minimal and a missing dose can be readily</td>
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<td>detected.</td>
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**Provider's Plan of Correction**

- No resident was affected.
- Staff will be instructed and policy reviewed regarding the storage of drugs and biologicals in the facility. Licensed personnel will sign an acknowledgement form regarding medication storage on or before 7/30/10.
- The contract pharmacist will do weekly checks for 90 days for compliance of medication storage. Results will be reported in monthly PI meeting starting July 30, 2010, for 90 days.
<table>
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<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>(X5) COMPLETION DATE</th>
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<td>F 431</td>
<td>Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, and observation, it was determined the facility failed to ensure 1 of 7 (Nurse #3) medication nurses kept medications in locked compartments. The findings included: Review of the facility’s &quot;Storage of Medications&quot; policy documented &quot;...Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications...&quot; Review of another untitled facility policy documented &quot;...PURPOSE: To ensure security of medications... storage of pharmaceuticals outside of the pharmacy will be restricted and under lock control...&quot; Medical record review for Random Resident (RR) #1 documented an admission date of 2/6/10 with diagnoses of Hypertension, Congestive Heart Failure, Gastroesophageal Reflux Disease, Irritable Bowel Syndrome, Renal Insufficiency, Anxiety/Depression, Osteoporosis, Osteoarthritis, Idiopathic Thrombocytopenia, and Mild Hypoglycemia. Review of the physician’s recertification orders for June 2010, signed but not dated, documented &quot;...ONE DAILY MULTIVIT [multivitamin] TAKE 1 TABLET BY MOUTH DAILY...&quot; Observations outside RR #1's room on 6/29/10 at 8:07 AM, revealed Nurse #3 left the bottle of</td>
<td>F 431</td>
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<td>F 431</td>
<td>Continued From page 9 Multivitamins on top of the medication cart unsecured while she administered RR #1's medications. The Multivitamin medication was not in the nurse's view.</td>
<td>F 441</td>
<td>Resident #19 with chronic stasis ulcer with no change and no adverse reactions.</td>
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<td>F 441</td>
<td>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.</td>
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<td>During staff meeting on or before July 30, 2010, infection control manager will review policy and procedure for cleaning, disinfection, and sterilization of equipment. All licensed nurses must complete the infection control module of media lab requirement by 7/30/10, with a passing grade of at least 80%. Infection control will be discussed at least quarterly by nursing educator ongoing.</td>
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<tr>
<td>F 441</td>
<td>Continued From page 10 transport linens so as to prevent the spread of infection.</td>
<td>F 441</td>
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This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review, observation, and interview, it was determined the facility failed to clean/disinfect equipment used during dressing change observations by 1 of 2 (Treatment Nurse #2) treatment nurses, and 2 of 7 (Nurse #1 and 4) nurses observed during medication administration failed to wash hands prior to gloving or after picking up a nose spray bottle from the floor or clean the bottle prior to use.

The findings included:

1. Review of the facility's "Cleaning, Disinfection, Sterilization Page: 2 of 5" documented, "...Semi-critical: Items that come in contact with mucous membranes or non-intact skin... Cleaning/disinfecting of semi-critical items: High-level disinfection with chemical disinfectant, rinse with sterile water... Frequency: After each use..."

Review of the facility's "Infection Control... Standard Precautions" policy documented, "...Standard precaution include the following practices: Hand hygiene... immediately after removing gloves..."

2. Medical record review for Resident #19 documented an admission date of 6/14/10 with diagnoses of Cerebrovascular Accident with Hemiplegia, Venous Stasis Ulcer Left (L) Inner
Continued from page 11:

Ankle with Methicillin Resistant Staphylococcus Aureus (MRSA) infection. Review of a
Physician's telephone order dated 6/18/10
documented, "Contact isolation precautions
wound MRSA." Orders dated 6/25/10
documented, ". N.O. [new order] clean stasis
ulcer c [with] Saf-Clen's, Apply Aquacel AG to
wound. Apply 4x [by] 4's, wrap c Kerlix daily &
[and] pm [as needed]." Review of a laboratory
(lab) report dated verified 6/17/10 documented,
"...Culture wound... site L lower leg... Final
Report... Organism #2: Methicillin Resistant Staph
Aureus..."

Observations in Room 33 on 6/29/10 at 8:30 AM,
revealed Treatment Nurse #2 removed a pair of
scissors from her pocket, cut the drainage soiled
dressing off of Resident #19's L ankle, MRSA
Infected Stasis Ulcer Wound, placed the
contaminated scissors on the barrier containing
the clean dressing supplies, then used the
contaminated scissors to cut the Aquacel AG
dressing to the correct size and placed the
Aquacel AG dressing on the wound. The
contaminated scissors were then placed back on
the barrier containing clean dressing supplies,
and the remaining contaminated Aquacel AG
dressing was placed in the bag containing clean
dressing supplies. Treatment Nurse #2 then
placed the contaminated scissors back into her
pocket without cleaning the scissors.

During an interview on the Skilled Hall on 6/29/10
at 8:50 AM, Treatment Nurse #2 stated, "I didn't
clean them [scissors], did I? I normally use
alcohol."

3. Observations outside Resident #17's room on
6/28/10 at 7:28 AM, revealed Nurse #1 dropped a
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<tr>
<td>F 441</td>
<td>Continued From page 12 bottle of Fluticasone nasal spray on the floor. Nurse #1 picked the bottle up, took it into the room, and administered the spray to Resident #17. Nurse #1 did not clean the bottle after it fell onto the floor, and she did not wash her hands after picking the bottle up off the floor. During an interview in Room 51 (surveyor room) on 6/30/10 at 9:50 AM, the Director of Nursing (DON) was asked what the nurse should have been expected to do when the bottle dropped on the floor. The DON stated, &quot;...clean the bottle...they should wash their hands...&quot;</td>
<td>F 441</td>
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<td>F 514</td>
<td>4. Observations in Random Resident (RR) # 2's room on 6/26/10 at 7:45 AM, revealed Nurse #4 administered resident's eye drops in RR #2's eyes, removed her gloves and reapplied another pair of the gloves to administer nasal spray without washing her hands. 483.75(l)(1) RES 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</td>
<td>F 514</td>
<td>Affected Resident #4 record was corrected immediately with current physician order. Complete resident review was done by July 1, 2010. Unit Coordinators, during monthly review will audit physician orders to ensure accuracy for 90 days and will report in monthly PI Committee meeting for 3 months. All monthly physician orders will be checked by Unit Managers and Unit Coordinators during first of the month review and with any change in status or orders.</td>
<td>7/01/10</td>
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**SUMMARY:**
- **F 441:** Bottle of Fluticasone nasal spray found in the floor. Nurse #1 did not clean the bottle after it fell, nor did she wash her hands afterward.
- **F 514:** Resident #4's clinical record was incorrectly reviewed, leading to a need for improved documentation and hygiene practices.
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<tr>
<td>F 514</td>
<td>Continued From page 13 by:</td>
<td>F 514</td>
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<td>Based on medical record review and interview, it was determined the facility failed to maintain complete and accurate medical records for physician's orders for 1 of 31 (Resident #4) sampled residents. The findings included: Medical record review of Resident #4 documented an admission date of 9/25/08 and readmission date of 5/19/08 with diagnoses of Spinocerebellar Degeneration with Ataxia, Dysarthria, Hypertension, and Gastrostomy with severe Dysphagia. The physician's phone order dated 10/16/09 documented, &quot;...comfort measures c [with] no weights per family request.&quot; The physician's recertification order dated 6/1/10 did not include an order to not weigh the resident. During an interview at the 400 Nurses Station on 6/28/10 at 2:15 PM, Nurse #5 stated &quot;Oh, I guess I didn't transfer it [not to weigh order] over to the current order.&quot;</td>
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