MT PLEASANT HEALTHCARE AND REHABILITATION

F 278 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on review of the Center's for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) version 3.0 Manual, medical record review and interview, it was determined the facility failed to accurately

F 278 483.20(g)-(j) Assessment Accuracy/Coordination/Certified

SS=D

The facility will accurately assess residents.

1. Resident # 19's Minimum Data Set was corrected by Minimum Data Set nurse on 7/11/13.
   Resident # 36's was corrected by Minimum Data Set nurse on 7/18/13. Resident # 47's Minimum Data Set was corrected by Minimum Data Set nurse on 7/11/13. Resident # 66's Minimum Data Set was corrected by Minimum Data Set nurse on 7/11/13.

2. 100% audit of residents' most current Minimum Data Set assessment to ensure the assessment accurately reflects residents' stay by interdisciplinary team 7/11/13 thru 7/22/13

3. Director of Nursing in-services Minimum Data Set nurse to ensure accurate coding of
Minimum Data Set assessments on 7/11/13.

4. Director of Nursing/Assistant Director of Nursing will audit all new Minimum Data Sets daily 5 x week x 12 weeks for accurate assessment of residents to reflect resident status. The results of this audit will be brought to monthly Quality Assurance meeting by Director of Nursing or Assistant Director of Nursing.

Quality Assurance members are Medical Director, Administrator, Director of Nursing, Resident Care Coordinator, Unit Manager, Minimum Data Set Coordinator and others as needed.

During an interview in the conference room on 7/10/13 at 8:30 AM, the MDS Coordinator was asked if the falls in March, April and June 2013 were documented on the quarterly MDS dated 6/15/13. The MDS Coordinator confirmed that it was not documented and stated, "I don't know..."

2. Review of the "CMS's RAI Version 3.0 Manual" documented, "...B1000: Vision... Steps
for Assessment... Test the accuracy of your findings... Ensure that the resident’s customary visual appliance for close vision is in place (e.g. [example], eyeglasses, magnifying glass)... 

Medical record review for Resident #36 documented an admission date of 4/7/13 with diagnoses of Atrial Fibrillation, Diabetes Mellitus, Hypothyroidism, Macular Degeneration, Anxiety State, Muscle Weakness, Bronchitis, Blindness in One Eye, Insomnia, Hypokalemia, Depressive Disorder and Generalized Pain. Review of the admission MDS assessment with an assessment reference date of 4/18/13 in section B1000 was coded as a "2", indicating moderately impaired - limited vision and B1200 was coded as a "0", indicating no corrective lenses used.

During an interview in Resident #36's room on 7/8/13 at 3:30 PM, Resident #36 stated she uses the magnifying glasses to read.

During an interview in the Social Worker's office on 7/9/13 at 5:25 PM, the Social Worker was asked why the MDS was marked no corrective lenses. The Social Worker stated, "...didn't use it in the interview... I don't always have them [residents] use the corrective lenses in the interview..."

During an interview in the MDS office on 7/10/13 at 8:56 AM, the MDS Coordinator was asked if the RAI manual gives any guidelines on using corrective lenses or the magnifying glass during the assessment. The MDS Coordinator stated, "Yes, use customary..."

3. Medical record review for Resident #47
F 278 Continued From page 3

documented an admission date of 5/2/13 with
diagnoses of End Stage Renal Disease, Diabetes
Mellitus, Chronic Airway Obstruction, Depressive
Disorder, Right Below the Knee Amputation and
Peripheral Vasculur Disease. Review of the
physician's orders dated 6/5/13 documented,
"...DIALYSIS 3X [times] AVK [week] ON TUES
[Tuesday], THURS [Thursday] & [and] SAT
[Saturday]..." Review of the 60 day MDS
assessment with an assessment reference date
of 6/27/13 in section 00100 J revealed no check
mark, indicating Resident #47 has not received
dialysis while a resident.

During an interview in the MDS Coordinator's
office on 7/10/13 at 10:45 AM, the MDS
Coordinator was asked if dialysis should have
been checked on the 60 day MDS. The MDS
Coordinator stated, "Yes."

4. Medical record review for Resident #66
documented an admission date of 5/28/13 and a
discharge date of 6/7/13 with diagnoses of
Metastatic Melanoma (comfort care), Diabetes,
Gastro Esophageal Reflux Disease, Neuropathy,
Depression, Anxiiety, Arthritis and Dyslipidemia.
Review of the "[Named] Medical Group"
Physician's History and Physical dated 5/25/13
documented, "...The patient is nonresponsive...
Metastatic squamous cell carcinoma versus
secondary carcinoma, terminal likely in next 3-
[10] 15 days... prognosis is terminal and the family
is very much aware..." Review of the admission
MDS assessment with an assessment reference
date of 6/4/13 in section J1400 was coded as a
"0", indicating the resident does not have a
condition or chronic disease that may result in a
life expectancy of less than 6 months.
F 278 Continued From page 4

During an interview in the MDS office on 7/10/13 at 8:50 AM, the MDS Coordinator was questioned concerning the terminal prognosis not documented on the 6/4/13 MDS. The MDS Coordinator confirmed the MDS should have documented as a terminal condition. The MDS Coordinator stated, "I did not see in the orders as a terminal prognosis... but it was documented in this record... so should have been documented in the MDS..."

F 279 483.20(d), 483.20(k)(1) DEVELOP

COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident’s comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being as required under §483.25, and any services that would otherwise be required under §483.25 but are not provided due to the resident’s exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

483.20 (d), 483.20(k)(1) Develop Comprehensive Care Plans

The facility will develop a comprehensive care plan.

2. 100% audit of all residents care plans to reflect resident’s current status from 7/11/13 thru 7/22/13.
3. Director of Nursing in-serviced Minimum Data Set nurse on 7/11/13 to ensure comprehensive care plan reflects resident’s current status.
4. Director of Nursing/Assistant
F 279  Continued From page 5

Based on medical record review and interview, it was determined the facility failed to ensure a comprehensive care plan was developed to address vision for 1 of 20 (Resident #36) sampled residents of the 33 residents included in the stage 2 review.

The findings included:

Medical record review for Resident #36 documented an admission date of 4/7/13 with diagnoses of Atrial Fibrillation, Diabetes Mellitus, Hypothyroidism, Macular Degeneration, Anxity State, Blindness in One Eye, Muscle Weakness, Bronchitis, Insomnia, Hypokalemia, Depressive Disorder and Generalized Pain. Review of the admission Minimum Data Set (MDS) dated 4/18/13 documented, "...Section V Care Area Assessment (CAA) Summary... 03. Visual Function... Care Area Triggered [checked]..." The care plan dated 4/19/13 did not address vision.

During an interview in the MDS office on 7/10/13 at 8:56 AM, the MDS Coordinator confirmed that vision was not addressed on the care plan.

F 280  483.20(d)(3), 483.10(k)(2) RIGHT TO
SS-D PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending

F 280  483.20(d)(3), 483.10(k)(2) Right to Participate Planning Care-Revise CP

The facility will revise care plans to accurately reflect changes in care with the patient.

1. Resident # 47's care plan was updated by Minimum Data Set
F 280 Continued From page 6

physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative, and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined that the facility failed to revise the care plan for emergency bleeding related to dialysis for 1 of 20 (Resident #47) sampled residents of the 33 residents included in the stage 2 review.

The findings included:

Medical record review for Resident #47 documented an admission date of 5/2/13 with diagnoses of End Stage Renal Disease, Diabetes Mellitus, Chronic Airway Obstruction, Depressive Disorder, Right Below the Knee Amputation and Peripheral Vascular Disease. Review of the physician's orders dated 6/5/13 documented, "...DIALYSIS 3X [times] / [per] WK [week] ON TUES [Tuesday], THURS [Thursday] & [and] SAT [Saturday]." The care plan dated 5/24/13 does not address emergency bleeding related to dialysis.

During an interview in the Minimum Data Set (MDS) office on 7/10/13 at 10:45 AM, the MDS nurse on 7/11/13.

2. 100% audit of all residents receiving dialysis. Care plans reviewed for emergency bleeding related to dialysis on 7/11/13. No residents identified to be affected.

3. Director of Nursing in-serviced Minimum Data Set nurse to ensure care plans are updated to reflect residents current condition on 7/11/13.

4. Director of Nursing/Assistant Director of Nursing will audit dialysis residents care plan for emergency bleeding 5 x week x 12 weeks and will report findings to the Quality Assurance members during the monthly meeting. Quality Assurance members are Medical Director, Administrator, Director of Nursing, Resident Care Coordinator, Unit Manager, Minimum Data Set Coordinator and others as needed.

7/23/13
<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<tbody>
<tr>
<td>Identification Number: 445374</td>
<td>A. BUILDING</td>
<td>07/10/2013</td>
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<tr>
<td>B. WING</td>
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NAME OF PROVIDER OR SUPPLIER: MT PLEASANT HEALTHCARE AND REHABILITATION

STREET ADDRESS, CITY, STATE, ZIP CODE: 904 HIDDEN ACRES DR MOUNT PLEASANT, TN 38474

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>(X5) COMPLETION DATE</th>
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</thead>
<tbody>
<tr>
<td>F 280</td>
<td></td>
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<td>Continued From page 7</td>
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<td></td>
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<td></td>
<td>Coordinator was asked if the dialysis care plan addressed emergency bleeding. The MDS Coordinator stated, &quot;No.&quot;</td>
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<td>During an interview in the conference room on 7/10/13 at 10:53 AM, the Director of Nursing (DON) was asked if she expected the care plan to address emergency bleeding. The DON stated, &quot;Yes.&quot;</td>
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</tbody>
</table>

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, observation and interview, it was determined the facility failed to follow physician's orders for 1 of 2 (Resident #23) sampled residents observed receiving medication patches of the 33 residents included in the stage 2 review.

The findings included:
Medical record for Resident #23 documented an admission date of 7/27/12 with diagnoses of Urinary Tract Infection, Hypertension, Asthma, Atrial Fibrillation, Wheezing, Dysphagia, Parkinson's Disease and Aftercare Trauma Fracture. Review of the physician's orders

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>F 280</td>
<td></td>
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<td>483.25 Provide Care/ Services for Highest Well Being</td>
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<tr>
<td>F 309</td>
<td></td>
<td></td>
<td>SS=D</td>
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</tbody>
</table>

The facility will follow physician's orders.

1. Patch dated 7/9/13 was removed by charge nurse on 7/10/13. Medical Director notified on 7/10/13 by Director of Nursing. No new orders. Resident assessed by Director of Nursing on 7/10/13 with no adverse outcomes noted. Nurse #1 was in-serviced by Director of Nursing on 7/10/13 on administration of patch.

2. 100% audit of residents receiving a patch had head to
F 309 Continued From page 8
dated 6/5/13 documented, "...EXELON 9.5 MG
[milligram] / 24 HR [hour] PATCH APPLY 1
PATCH TOPICALLY DAILY "REMOVE OLD
PATCH..."

Observations in Resident #23's room on 7/10/13
at 7:15 AM, revealed an Exelon patch on
Resident #23's right upper back dated 7/9/13 and
an Exelon patch on her left upper chest dated
7/10/13.

During an interview in Resident #23's room on
7/10/13 at 7:15 AM, the Director of Nursing was
asked about the second patch on Resident #23.
The DON stated, "...She [Nurse #1] should have
removed the patch [Exelon patch dated 7/9/13]..."

During an interview in Resident #23's room on
7/10/13 at 7:20 AM, Nurse #1 stated, "I couldn't
find it [Exelon patch dated 7/9/13]..."

F 318 483.25(e)(2) INCREASE/PREVENT DECREASE
IN RANGE OF MOTION

Based on the comprehensive assessment of a
resident, the facility must ensure that a resident
with a limited range of motion receives
appropriate treatment and services to increase
range of motion and/or to prevent further
decrease in range of motion.

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 ensure residents with limitations in
range of motion (ROM) received care and
toe assessment to ensure one
patch was applied was
completed by Director of
Nursing on 7/11/13.

3. Director of Nursing and/or
Assistant Director of Nursing
began in-service licensed
nurses on 7/10/13 through
7/22/13 on patch
administration.

4. Director of Nursing or Assistant
Director of Nursing will audit 4
residents a day 5 x week x 4
weeks to ensure proper patch
administration, then 3 x week x
4 weeks, then 1 x week x 4
F 309 Continued From page 8

dated 6/5/13 documented, "...EXELON 9.5 MG [milligram] / 24 HR [hour] PATCH APPLY 1
PATCH TOPICALLY DAILY "REMOVE OLD
PATCH..."

Observations in Resident #23's room on 7/10/13
at 7:15 AM, revealed an Exelon patch on
Resident #23's right upper back dated 7/9/13 and
an Exelon patch on her left upper chest dated
7/10/13.

During an interview in Resident #23's room on
7/10/13 at 7:15 AM, the Director of Nursing was
asked about the second patch on Resident #23.
The DON stated, "...She [Nurse #1] should have
removed the patch [Exelon patch dated 7/9/13]..."

During an interview in Resident #23's room on
7/10/13 at 7:20 AM, Nurse #1 stated, "I couldn't
find it [Exelon patch dated 7/9/13]..."

F 318 483.25(e)(2) INCREASE/PREVENT DECREASE
SS=D IN RANGE OF MOTION

Based on the comprehensive assessment of a
resident, the facility must ensure that a resident
with a limited range of motion receives
appropriate treatment and services to increase
range of motion and/or to prevent further
decline in range of motion.

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 ensure residents with limitations in
range of motion (ROM) received care and

weeks and / or 100%
compliance. The results of this
audit will be brought to
monthly Quality Assurance
meeting by Director of Nursing
or Assistant Director of Nursing.
Quality Assurance members are
Medical Director,
Administrator, Director of
Nursing, Resident Care
Coordinator, Unit Manager,
Minimum Data Set Coordinator
and others as needed.

F 309 F 318

483.25(e)(2) Increase/ Prevent decrease
in range of motion

SS=D

The facility will ensure that residents
with limitations in range of motion
receive care and treatment to prevent
further decline in range of motion.

1. Resident # 12 was assessed by
Director of Nursing on 7/9/13
and palm protectors were in
<table>
<thead>
<tr>
<th>F 318</th>
<th>Continued From page 9</th>
<th>F 318</th>
<th>place on right and left hands.</th>
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</thead>
<tbody>
<tr>
<td>treatment to prevent further decline in ROM for 1</td>
<td>Resident Care Coordinator</td>
<td></td>
<td>Resident Care Coordinator</td>
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<tr>
<td>of 4 (Resident #12) sampled residents with</td>
<td>updated Activities of Daily</td>
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<td>updated Activities of Daily</td>
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<td>contractures of the 33 residents included in the</td>
<td>Living sheet on 7/9/13</td>
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<td>Living sheet on 7/9/13</td>
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<td>stage 2 review.</td>
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<td>2.</td>
<td>100% audit of all residents with</td>
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<td>palm protectors to ensure palm</td>
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<td>The findings included:</td>
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<td>protectors were in use as</td>
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<td>Review of the facility's ROM active and passive</td>
<td></td>
<td>ordered and documented on</td>
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<td>policy documented, &quot;...For some residents, this</td>
<td></td>
<td>the Activities of Daily Living</td>
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<td>ROM can be achieved during their normal daily</td>
<td></td>
<td>sheet by Director of Nursing</td>
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<td>routine of ADL's [Activities of Daily Living]...&quot;</td>
<td></td>
<td>and Resident Care Coordinator</td>
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<td></td>
<td>Medical record review for Resident #12</td>
<td></td>
<td>on 7/9/13 thru 7/11/13</td>
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<td>documented an admission date of 4/23/08 with</td>
<td></td>
<td>3. In-service Certified Nursing</td>
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<td>diagnoses of General Muscle Weakness,</td>
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<td>Assistants' on documentation</td>
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<td>Esophageal Reflux, Dysphagia, Hyperlipidemia,</td>
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<td>of palm protector use on</td>
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<td>Alzheimer's Disease, Paranoid State, Psychosis,</td>
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<td>Activities of Daily Living</td>
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<td>Anxiety State, Diabetes Mellitus, and Urinary</td>
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<td>sheet and following physician orders</td>
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<td>Incontinence. Review of the annual Minimum</td>
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<td>by Resident Care Coordinator</td>
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<td>Data Set (MDS) dated 9/14/12 and the quarterly</td>
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<td>on 7/11/13 to 7/17/13</td>
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<td>4. 100% audit of all residents with</td>
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<td>G.400. Functional Limitation in Range of Motion...</td>
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<td>palm protectors to be checked</td>
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<td>Upper extremity... [coded] 2 [indicating</td>
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<td>1 x daily 5 x a week for 4 weeks</td>
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<td>impairment on both sides]... Lower extremity ...</td>
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<td>and 3 residents 3 x a week x 8</td>
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<td>[coded] 2...&quot; Review of the care plan dated</td>
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<td>9/18/12 and updated 1/18/13 documented, &quot;...Self</td>
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<td>documentation and placement.</td>
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<td>care deficit with risk for decline in skin integrity...</td>
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<td>Findings will be reported to the</td>
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<td></td>
<td>Gentle PROM [passive ROM] to BUE [bilateral upper</td>
<td></td>
<td>Quality Assurance members</td>
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<td>extremities] and BLE [bilateral lower extremities]</td>
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<td>during the monthly meeting.</td>
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<td>during ADL... palm protectors to</td>
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<td>Quality Assurance members are</td>
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<td>bilateral hands...&quot;</td>
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<td>Medical Director,</td>
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<td>Review of the physician orders dated 6/5/13</td>
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<td>documented, &quot;...GENTLE PROM TO BUE &amp; [and]</td>
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<td>BLE DURING ADL CARE, PALM PROTECTORS</td>
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<td>TO BIL [bilateral] HANDS, OFF DURING</td>
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<td>BATH...&quot; Review of Resident #12's personal care</td>
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<td></td>
<td>record for 7/11/13 through 7/31/13 documented,</td>
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F 318 Continued From page 10

"...PROM BUE... Palm Protectors..." There is no documentation on the form that this intervention was done.

Observations in Resident #12's room on 7/8/13 at 11:30 AM and 2:18 PM, revealed Resident #12 lying in bed with no palm protector on the left hand.

Observations in Resident #12's room on 7/9/13 at 7:56 AM and 8:30 AM, revealed Resident #12 lying in bed with the palm protector partially on the right hand. There was not a palm protector on the left hand. At 9:30 AM, the palm protector was completely off the right hand.

Observations in Resident #12's room on 7/9/13 at 1:15 PM, revealed Resident #12 sitting in a wheelchair. The palm protector was completely off her right hand. There was no palm protector on her left hand.

During an interview in front of the nurses' station on 7/9/13 at 2:00 PM, certified nursing assistant (CNA) #1 was asked if Resident #12 had contractures. CNA #1 stated, "Yes, both hands..." CNA #1 was asked about ROM exercises and the palm protectors. CNA #1 stated, "Do ROM on all extremities once a day... wears brace all day..." CNA #1 was asked if the ROM exercises and palm protectors were documented. CNA #1 stated, "It's in our ADL book..."

During an interview in the conference room on 7/9/13 at 2:40 PM, the Director of Nursing confirmed that the ROM and palm protector application should have been documented.

Administrator, Director of Nursing, Resident Care Coordinator, Unit Manager, Minimum Data Set Coordinator and others as needed. 7/23/13