**NAME OF PROVIDER OR SUPPLIER**

HIDDEN ACRES HEALTH CARE CENTER

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

504 HIDDEN ACRES DR
MOUNT PLEASANT, TN 38474

### Summary of Deficiencies

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<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 280</td>
<td>SS=dD</td>
<td>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</td>
<td>F 280</td>
<td>SS=dD</td>
<td>This plan of correction is submitted as required under state law. The submission of this plan of correction does not constitute an admission on the part of Hidden Acres Health Care to the accuracy of the surveyor's findings nor the conclusions drawn therefrom. The facility's submission of this plan of correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.</td>
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- The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

- A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an Interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

- This REQUIREMENT is not met as evidenced by:

  - Based on medical record review, observation and interview, it was determined the facility failed to update the care plan or implement new interventions for behaviors for 1 of 16 (Resident #6) sampled residents.

- The findings included:

  - Medical record reviewed for Resident #6 documented an admission date of 4/1/04 and a re-admission date of 5/7/09 with diagnoses of Cerebral Vascular Accident (CVA), Hemiplegia, Hypertension, Anxiety State, Depressive Disorder

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**Signature**

Pamela L. Adams 5-17-10

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**Notes**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above and any other deficiencies that are not cited in this document are due to the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are due to the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are due to the date of survey whether or not a plan of correction is provided.
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<td>F 280</td>
<td>Continued From page 1 and Explosive Personality. Review of a Psychiatric Services Behavioral Medicine Progress Note dated 10/1/09 documented, &quot;off med (Ativan 0.8 mg [milligrams] every 8 hours as needed) since September (2009). No issues per staff.&quot; There were no Psychiatric Services Behavior Notes after 10/1/09. Review of the Physician's orders for October 2009 through April 19, 2010 did not include any medications ordered for behaviors or agitation exhibited by Resident #6. Review of the Nurse's Notes dated 11/28/09 through 4/19/10 documented, that Resident #6 had 25 instances of exhibiting behaviors which included: yelling, cursing, resisting care, grabbing and pinching staff, attempting to bite staff and digging nails into staff. Review of Resident #6's care plan dated 5/18/09 documented, &quot;Problem: Altered mood and behaviors AEB [as exhibited by] persistent anger with self or others and resistant to care. Approaches included: Comfort and reassure as needed. [Named Psychiatric Service] to evaluate and consult as needed.&quot; An update to the care plan dated 11/3/09 documented, &quot;Increased yelling out.&quot; There were no new interventions documented. An update to the care plan dated 1/28/10 documented, &quot;Continue to attempt to calm and reassure as able. He has began to yell out frequently.&quot; There were no new care plan interventions documented after 1/28/10. Observations in Resident #6's room on 4/19/10 from 12:20 through 12:25 PM, revealed Resident</td>
<td>F 280</td>
<td>Social Services Director will receive confirmation of all referrals submitted to psychiatric services to ensure residents are seen timely, and Interdisciplinary Team will review weekly all residents with instances of exhibiting behaviors and ensure new interventions have been put into place. 4. DON will periodically monitor care plans and chart audits to assure compliance. Findings will be presented to QI Committee. The DON or Administrator will monitor to ensure ongoing compliance.</td>
<td>4/21/10</td>
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F 280
#6 lying in bed on his back yelling out loudly.

During an interview at the Nurses' Station on 4/20/10 at 4:30 PM, the Director of Nursing (DON) stated, "We don't have a written Behavioral Program, but we are working on it. If behaviors continued, I would expect the care plan to be updated with interventions." The DON also stated, Resident #6's care plan has not been updated with new interventions since 1/28/10 and there are no new Psychiatric Service consults since 10/1/09.

F 390 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 and interviews, it was determined the facility failed to follow the physician's orders for medication administration and/or referral to psychological services for 2 of 16 (Residents #1 and 7) sampled residents.

The findings included:

1. Medical record reviewed for Resident #1 documented an admission date of 3/24/10 with diagnoses of History of Atrial Fibrillation, Hypertension (HTN), Cerebrovascular Accident, Chronic Obstructive Pulmonary Disease, Deep
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<tr>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<tbody>
<tr>
<td>A. BUILDING</td>
<td>04/21/2010</td>
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<td>B. WING</td>
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Venn Thrombosis, Degenerative Joint Disease of the Back, Venous Stasis and Diabetes Mellitus Type II. Review of Resident #1's Physician's orders dated 4/6/10 documented "...DILTIAZEM CD ER 120 MG [milligrams] TAKE 1 CAPSULE BY MOUTH ONCE EVERY MORNING (HOLD SBP [SYSTOLIC BLOOD PRESSURE] < [LESS THAN] 120... HYDRALAZINE 25 MG TABLET TAKE 1 TABLET BY MOUTH THREE TIMES DAILY (HOLD SBP <110)..."  
Review of the vital sign flow sheet documented Resident #1's BP results on 3/25/10 - 107/58, 4/1/10 - 113/48, 4/5/10 - B/P 108/64, 4/8/10 - B/P 108/55, 4/14/10 - B/P 110/64, 4/16/10 - B/P 98/68 and 4/17/10 - B/P 113/63. (Note the first number is the systolic blood pressure reading).  
Review of the Medication Administration Records (MAR) for 3/25/10 through (-) 4/30/10 documented Hydralazine 25 mg was administered at 9A, 3P and 9P on, 3/25/10, 4/5/10, 4/8/10 and 4/16/10. The facility failed to follow the Physician's hold order to hold the Hydralazine for a SBP <110 on 3/25/10, 4/5/10, 4/8/10 and 4/16/10.  
Review of the MAR for 3/25/10 - 4/30/10 documented, Diltiazem CD ER 120 mg 1 capsule by mouth every morning hold if SBP <120. Diltiazem was documented as being administered in the morning on 3/25/10, 4/1/10, 4/5/10, 4/8/10, 4/14/10, 4/16/10 and 4/17/10. The facility failed to follow the Physician's hold order to hold Diltiazem for SBP <120 on 3/25/10, 4/1/10, 4/5/10, 4/8/10, 4/14/10, 4/16/10 and 4/17/10.  
During an interview in the hallway outside of room #13 on 4/19/10 at 4:40 PM, Nurse #1 stated, "B/P | F 309  | Orders are reviewed by MDS Coordinator/DON and Interdisciplinary team daily to ensure orders are followed.  
4. Chart audit of orders written will be completed periodically by DON or designee to ensure that facility is in compliance with following physician orders. Findings will be reported to the QI committee. DON will monitor for ongoing compliance. | 4/21/10 |

4/21/10
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should have been recorded on the MAR..." Nurse #1 was asked if the administered Hydralazine and Diltiazem doses should have been held per the Physician's orders. Nurse #1 stated, "Yes."

2. Medical record review for Resident #7 documented an admission date of 4/1/04 with diagnoses of Vascular Dementia with Delusion, Osteoporosis, Vascular Dementia with Depression, Special Symptom, Hypertension and Constipation. Review of Resident #7's Physician's orders dated 4/8/10 documented "...REFER TO [name of contracted PSYCH [Psychiatric] SERVICES..." Review of the Social Service Progress Notes did not have documentation of a referral for psychological services for Resident #7.

During an interview in the Nurses Station on 4/20/10 at 11:55 AM, Nurse #2 stated, "...[named Resident #7] doesn't have anything [referral for psychiatric services] for that time frame [April 2010]."

During an interview in the Social Services office on 4/20/10 at 12:12 AM, the Social Services Director stated, "...I was not aware we needed one [4/8/10 referral for psychological services] within the past year... is that [psychological services] needed? ...if it's on the Doctor's order then we need to try [arrange for Resident #7's psychological service appointment]... I'll go talk to [Resident #7] and document that right now."

F 431
SS-D

483.60(b), (d), (e) DRUG RECORDS,
LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all
Continued From page 6
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 policy review, observation and
interviews, it was determined the facility failed to
ensure proper storage of medications by not
removing expired medications from 1 of 4
(Nurses' Station Medication Room) medication
storage areas.

F 431 Drug Records, Label/Store Drugs &
Biologicals

The facility will ensure the proper storage of
medications.

1. No residents were found to be affected by
the alleged practice.

2. All residents have the potential to be af-
fected. All medications checked by DON/
ADON to ensure that medications are not past
the expiration dates.

3. Emergency Back-Up Boxes located in med-
room are checked nightly by licensed nurses to
ensure no medications are stored past the expira-
tion date. Med Carts are checked by RN Su-
ervisor weekly to ensure no medications are
served past the expiration date. Pharmacist and/
or Pharmacy Med Tech checks med carts, med
room, and emergency back-up boxes during
facility visits. Report made Monday - Friday by
DON/ADON in department head morning
meeting to ensure facility is in compliance with
proper storage of medications. All licensed
nurses inserviced by DON on 4/21/10 on pro-
ocol for returning medications to pharmacy prior
to expiration date. The DON spoke with Phar-
macy Consultant on 4/20/10 regarding protocol
for verifying carts, med room, and back-up
boxes to insure no meds are expired.

4. Pharmacy Consultant/Med Tech and DON
will check all meds monthly during pharmacy
review. The ADON will monitor emergency
boxes' checklist to ensure nurses are checking
nightly, and verify nursing staff is checking
carts and med room. All findings will be re-
ported to Qi Committee. DON will monitor for
ongoing compliance.
The findings included:

Review of the facility's "Storage of Medications" policy documented, "...The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed."

Observations in the Nurses' Station Medication Room on 4/20/10 at 8:35 AM, revealed 2 bottles of Fortaz 1 gram medication stored past the expiration date of 3/2010.

During an interview in the Nurse's Station medication room on 4/20/10 at 8:35 AM, Nurse # 3 stated, "...yes, they [two bottles of Fortz] are expired."

During an interview in the hall beside the Director of Nursing's (DON) office on 4/20/10 at 9:15 AM, the DON stated, "...Nurses' are responsible for checking expiration dates of medications.

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

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<tr>
<td>F 441</td>
<td>SS=F 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</td>
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<td>F 441</td>
<td>441 Infection Control, Prevent Spread, Linens</td>
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The facility will ensure a safe, sanitary and comfortable environment and help prevent the development and transmission of disease and infection.

1. No residents were found to be affected by the alleged practice.
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1. Preventing Spread of Infection
   - (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
   - (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
   - (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

2. All residents who the facility does laundry for have the potential to be affected.

3. A Ruud Model #RHNG0408900947 Tankless Water Heater with a Ruud Main Control #UMC117 digital temp readout has been installed on 5/4/10 servicing only laundry equipment. Employees were provided on 4/20/10 by Laundry Supervisor on proper recording water temps prior to each load of laundry. A new temperature log has been provided for recording temps. Water temp is being constantly held at 160 degrees by the new tankless water heater.

4. The Laundry Supervisor and Administrator will monitor temp logs and temp readout regularly to assure continued compliance with 160 degree water temps. Findings will be reviewed by the QA Committee. Laundry Supervisor will report back to QA Committee each month for a 3-month period to report continued compliance. Laundry Supervisor and Maintenance Supervisor will continue to monitor periodically to assure continued compliance of procedures and temps.

This REQUIREMENT is not met as evidenced by:
Based on policy review, observation and interview, it was determined the facility failed to ensure safe and aseptic washing of linen by not following the facility's policy by utilizing wash water too low to destroy microorganisms in 2 of 2 washers for 62 of 62 Residents.

The findings included:

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Observations in the facility's laundry room on 4/20/10 at 9:30 AM, revealed the temperature of hot water to be 119 degrees F when checked by the Laundry Supervisor.

Observations in the facility's laundry room on 4/21/10 at 7:45 AM, revealed the hot water temperature to be 122 degrees F when checked by the Maintenance Manager.

During an interview in the maintenance room, on 4/21/10 at 7:50 AM, the Maintenance Manager stated, "...I turned the temperature up on the hot water heater but this effects the residents' water temperature and I am going to turn the temperature back down now..."

During an interview in the laundry room on 4/21/10 at 9:30 AM, the Laundry Supervisor stated, "...I am going to check the temperature on the hot water in the mornings at the sink, the Maintenance Manager showed me how to do this..."