The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:

A description of the manner of protecting

<table>
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<tr>
<th>LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE</th>
<th>TITLE</th>
<th>(X5) DATE</th>
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<tbody>
<tr>
<td>[Signature]</td>
<td>[Title]</td>
<td>12/10/2013</td>
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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 are disclosable 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 disclosable 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.
F 156 NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

1. Residents # 23, # 40 and #41 were effected by this practice by not having a signed Medicare Provider Non-Coverage form. The forms were not signed by the resident or representative.

2. All residents receiving Medicare benefits have the potential to be affected by this deficient practice.

3. The Social Service Director was inserviced on 12/5/13 and Resident Assessment Coord. was Inserviced on 11/25/13 that the facility will notify the resident/family representative orally and in writing with a signed and dated notice, the facility will request the form to be returned via mail with a signed signature upon receipt of the written notice.

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 are disclosable 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 disclosable 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.
F 156  Continued From page 1

personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple’s non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse’s medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by

4. The Administrator / designee will monitor the proper liability and appeal notice with a date and signature from the resident or representative quarterly for 2 quarters and randomly thereafter. Any findings will be reported to the Quality Assurance Performance improvement (QAPI) committee for review and recommendations as needed.

The QAPI committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Resident Assessment Coordinator, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Maintenance Director, Social Services Director, Activities Director and Qualified Disability Intellectual Professional (QDIP).
This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to provide the appropriate liability and appeal notice for 3 of 3 (Residents #23, 40 and 41) sampled residents.

The findings included:

1. Review of the "NOTICE OF MEDICARE PROVIDER NON-COVERAGE" form for Resident #23 documented, "...THE EFFECTIVE DATE COVERAGE OF YOUR CURRENT: SERVICES WILL END: 09/06/2013..." The form is not signed or dated by the resident or representative.

2. Review of the "NOTICE OF MEDICARE PROVIDER NON-COVERAGE" form for Resident #40 documented, "...THE EFFECTIVE DATE COVERAGE OF YOUR CURRENT: SERVICES WILL END: 05/15/2013..." The form is not signed or dated by the resident or representative.

3. Review of the "NOTICE OF MEDICARE PROVIDER NON-COVERAGE" form for Resident #41 documented, "...THE EFFECTIVE DATE COVERAGE OF YOUR CURRENT: SERVICES WILL END: 11/05/2013..." The form is not signed or dated by the resident or representative.

4. During an interview in the conference room on 11/25/13 at 4:17 PM, the Resident Assessment Coordinator (RAC) was asked why the notices were not signed. The RAC stated, "I send them out by regular mail... with a self addressed stamp..."
F 156 Continued From page 3

evelope..." The RAC was asked if she had evidence that the notices were received. The
RAC stated, "No."

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO
PARTICIPATE PLANNING CARE-REVIEW 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
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 policy review, medical record review
and interview, it was determined the facility failed
to revise the care plan for rehabilitation/therapy
services for 1 of 19 (Resident # 21) sampled
residents reviewed of the 32 residents included in
the stage 2 review.

The findings included:

F 280 RIGHT TO
PARTICIPATE PLANNING CARE-REVIEW CP

1. Resident #21 was
affected by this
practice, the careplan
for this resident was
updated by the
Resident Assessment
Coordinator on 11/25
to reflect the
rehabilitative /therapy
services being provided
for this resident.

2. All residents have the
potential to be affected
by this deficient
practice.

3. The Resident
Assessment Coordinator was
inserviced on 11/25/13
by the Director of
Nursing to update and
revise all care plans
with any changes in
resident condition /
care on new physician
orders.
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
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<tbody>
<tr>
<td>445184</td>
<td>A. BUILDING</td>
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<td>B. WING</td>
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**NAME OF PROVIDER OR SUPPLIER**

PALMYRA HEALTH CARE CENTER

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

2727 PALMYRA RD
PALMYRA, TN 37142

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Review of the facility's "Care Plans - Comprehensive" policy documented, "...5. Care plans are revised as changes in the resident's condition dictate. Care plans are reviewed at least quarterly..."

Medical record review for Resident #21 documented an admission date of 9/10/13 and a readmission date of 9/25/13 with diagnoses of Cellulitis, Diabetes Mellitus, Depression, Acute Kidney Failure, Hypertension, Presenile Dementia, Gout, Open Wound Buttock and Anemia. Review of the physician's orders dated 9/10/13 documented, "Physical Therapy (PT) / Occupational Therapy (OT) / Speech Therapy (ST) evaluations and treatment as needed and/or indicated." Review of the physician telephone orders dated 9/12/13 documented, "PT clarification: PT to treat patient 5 x [times] / [per] week x 4 weeks for the [therapeutic] ex [exercises], therapeutic activities, gait training, patient education..."

Review of the 5 day Minimum Data Set (MDS) dated 9/17/13 documented Resident #21 began Physical Therapy (PT) and Occupational Therapy (OT) on 9/12/13 and both were ongoing. Review of the 60 day MDS dated 11/8/13 documented, PT and OT began 9/12/13 and both are ongoing. Review of the care plan dated 9/19/13 had no documentation for PT/OT therapies after the initial screening.

During an interview in the Director of Nursing's office on 11/25/13 at 10:37 AM, the Resident Assessment Coordinator (RAC) was asked about Resident #21's care plan regarding his rehab or therapies. The RAC stated, "...I have his therapy

**Provider's Plan of Correction**

(Each corrective action should be cross-referenced to the appropriate deficiency)

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4. The Director of Nursing /designee will monitor care plans for compliance weekly times 4 then . monthly , times 3 , randomly there after and report any findings to the Quality Assurance and Performance Improvement (QAPI) committee for review and recommendations as needed. The QAPI committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Resident Assessment Coordinator, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Maintenance Director, Social Service Director and Qualified, Activities Director, Qualified Intellectual Disability Professional (QIDP).
Continued from page 5

screening on there [care plan]... he is currently still in therapy...

483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE

The facility must ensure that it is free of medication error rates of five percent or greater.

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 maintain a medication error rate of less than 5 percent (%) as evidenced by 1 of 3 (Nurse #1) medication nurses made 2 medication errors out of 28 opportunities for error, which resulted in a medication error rate of 7.14%.

The findings included:

1. Review of the facility's "Administering Medications" policy documented, "...Medications must be administered in accordance with the orders..."

2. Medical record review for Resident #36 documented an admission date of 7/21/10 with diagnoses of Morbid Obesity, Hypertension, Gout, Depressive Disorder, Chronic Airway Obstruction and Diabetes Mellitus. Review of the physician's orders for Resident #36 documented, "...BUPROPION TAB [tablet] 100MG [milligrams],... TAKE 3 TABLETS [300MG] BY MOUTH DAILY WITH 75MG = [for a total of] 375MG... BUPROPION TAB 75MG... TAKE 1 TABLET BY MOUTH DAILY WITH 300MG =

F 332  FREE OF MEDICATION ERROR RATES OF 5% OR MORE  12/16/13

1. Residents #36 and #37 were effected by this practice. Resident #36 on 11/25/13 the pharmacy was notified by the charge nurse of incorrect dosage of medication and the need for the correct dosage. The pharmacy delivered the correct dosage of medication for Resident #36 on 11/25/13 and the medication was administered per physician order. The Exelon patch was left in place for resident #37.

2. All residents receiving medication have the potential to be affected by this deficient practice.
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Observations in Resident #36's room on 11/25/13 at 8:05 AM, revealed Nurse #1 administered 3 Bupropion Hydrochloride (HCL) 100 mg tablets to Resident #36. The failure to administer Bupropion 75 mg to equal to ordered dosage of 375 mg resulted in medication error #1.

During an interview at the nurses' station on 11/25/13 at 9:45 AM, Nurse #1 was asked about Resident #36's Bupropion order. Nurse #1 confirmed Resident #36 should have been given 375 mg according to the physician's order.

3. Medical record review for Resident #37 documented an admission date of 7/11/11 with diagnoses of Hyperlipidemia, Depressive Disorder, Morbid Obesity, Cerebrovascular Accident, Hypertension, Lymphedema, Cardiomegaly, Vascular Dementia and Peripheral Vascular Disease. Review of the physician's orders documented, "...EXELON DIS 9.5MG/24... APPLY 1 PATCH TO CLEAN, DRY SKIN TOPICALLY EVERY MORNING "REMOVE OLD-PATCH"..."

Observations in Resident #37's room on 11/25/13 at 8:29 AM, revealed Nurse #1 removed an old Exelon patch from Resident #37's left upper chest near his shoulder and applied a new Exelon patch to his left upper arm without cleaning the area before application of the patch. The failure to clean the area before the patch was administered resulted in medication error #2.

During an interview at the nurses' station on 11/25/13 at 9:45 AM, Nurse #1 was asked about administration of the Exelon 9.5 mg/24 hours...
F 332: Continued From page 6
375MG...

Observations in Resident #36's room on 11/25/13 at 8:05 AM, revealed Nurse #1 administered 3 Bupropion Hydrochloride (HCL) 100 mg tablets to Resident #36. The failure to administer Bupropion 75 mg to equal to ordered dosage of 375 mg resulted in medication error #1.

During an interview at the nurses' station on 11/25/13 at 9:45 AM, Nurse #1 was asked about Resident #36's Bupropion order. Nurse #1 confirmed Resident #36 should have been given 375 mg according to the physician's order.

3. Medical record review for Resident #37 documented an admission date of 7/11/11 with diagnoses of Hyperlipidemia, Depressive Disorder, Morbid Obesity, Cerebrovascular Accident, Hypertension, Lymphedema, Cardiomegaly, Vascular Dementia and Peripheral Vascular Disease. Review of the physician's orders documented, "...EXELON DIS 9.5MG/24... APPLY 1 PATCH TO CLEAN, DRY SKIN TOPICALLY EVERY MORNING "REMOVE OLD-PATCH"...

Observations in Resident #37's room on 11/25/13 at 8:29 AM, revealed Nurse #1 removed an old Exelon patch from Resident #37's left upper chest near his shoulder and applied a new Exelon patch to his left upper arm without cleaning the area before application of the patch. The failure to clean the area before the patch was administered resulted in medication error #2.

During an interview at the nurses' station on 11/25/13 at 9:45 AM, Nurse #1 was asked about administration of the Exelon 9.5 mg/24 hours...
F 332 Continued From page 7
patch to Resident #37 without first cleansing the
area where the patch was applied. Nurse #1
stated, "I knew to do that and I just forgot."

F 425 483.60(a),(b) PHARMACEUTICAL SVC -
ACCURATE PROCEDURES, RPH

The facility must provide routine and emergency
drugs and biologicals to its residents, or obtain
them under an agreement described in
§483.75(h) of this part. The facility may permit
unlicensed personnel to administer drugs if State
law permits, but only under the general
supervision of a licensed nurse.

A facility must provide pharmaceutical services
(including procedures that assure the accurate
acquiring, receiving, dispensing, and
administering of all drugs and biologicals) to meet
the needs of each resident.

The facility must employ or obtain the services of
a licensed pharmacist who provides consultation
on all aspects of the provision of pharmacy
services in the facility.

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 medications were
available to be administered as ordered for 1 of 4
(Resident #36) residents observed during
medication administration.

The findings included:

1. Resident #36 was
affected by this practice.
The correct Medication
(Bupropion ) for resident
#36 was delivered by the
pharmacy on 11/25/13.
The Correct dosage of
medication was
administered by the
licensed nurse to resident #
36 on 11/25/13 per
Physician order.
2. All residents receiving
medications have the
potential to be affected by
this deficient practice.
3. The facility’s licensed
nurses were inserviced by
the Director of Nursing on
Summary Statement of Deficiencies

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<th>Description</th>
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| F425 | Continued From page 8 | Review of the facility's "MEDICATION ORDERING AND RECEIVING FROM PHARMACY PROVIDER" policy documented, "...Medications and related products are received from the [Named Pharmacy] on a timely basis..."

Medical record review for Resident #36 documented an admission date of 7/21/10 with diagnoses of Morbid Obesity, Hypertension, Gout, Depressive Disorder, Chronic Airway Obstruction and Diabetes Mellitus. Review of the physician's orders for Resident #36 documented, "...BUPROPION TAB 100MG... TAKE 3 TABLETS [300MG] BY MOUTH DAILY WITH 75MG = [for a total of] 375MG... BUPROPION TAB 75MG... TAKE 1 TABLET BY MOUTH DAILY WITH 300MG = 375MG..."

Observations on A hall on 11/25/13 at 7:57 AM, revealed Nurse #1 removed 3 Bupropion Hydrochloride (HCL) 100 milligram (mg) tablets from prefilled packets provided by the pharmacy to be administered to Resident #36.

Observations in Resident #36's room on 11/25/13 at 8:05 AM, Nurse #1 administered 3 Bupropion HCL 100 mg tablets to Resident #36. The failure to administer Bupropion 75 mg to equal to ordered dosage of 375 mg resulted in a medication error.

During an interview at the nurses' station on 11/25/13 at 9:45 AM, Nurse #1 was asked about Resident #36's Bupropion order. Nurse #1 confirmed Resident #36 should have been given 375 mg according to the physician's order. Nurse #1 confirmed the prefilled packages provided by pharmacy did not include a Bupropion HCL 75

11/25 regarding the correct dosage of medication to be administered per physician orders. The licensed nurses administering medications will monitor that the pharmacy has delivered the correct dosages of medications on an ongoing basis.

4. The Director of Nursing/designee will monitor for any pharmacy discrepancies weekly times 4, monthly times 2 and randomly there after. All findings will be reported to the QAPI committee for review and recommendations as needed.
### Summary Statement of Deficiencies

**ID**: F 425

**Tag**: Continued From page 9

The pharmacy should have caught it first. Then the nurse.

During an interview in the conference room on 12/16/13 at 12:05 PM, the Certified Pharmacy Technician (CPhT) was asked about the pharmacy providing Bupropion correctly for Resident #36. The CPhT stated, "We've got a system in place to check the packages... from what I understand that system was down... it was manually verified... from what I understand they were mispackaged... we are on a 7 day cycle... when one of those machines goes down it creates issues..."

**ID**: F 425

The QAPI committee consists of the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Dietary Manager, Maintenance, Medical Records Coordinator, Director Social Services, Director, Activities, Director, Medical Records Coord., Maintenance, Director and Qualified Intellectual Disability Professional (QIDP).