### Initial Comments

Complaint investigation #32059, and #32622 were completed on October 21, 2013. Deficiencies cited related to complaint investigation #32059, and #32622, under 42 CFR Part 483, Requirements for Long Term Care.

**F 226**

**DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES**

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This **REQUIREMENT** is not met as evidenced by:

- Based on medical record review, review of facility policy, and interview, the facility failed to follow its own policy for misappropriation of resident property for three residents (#3, #5, #8) of eight residents reviewed.

The findings included:

- Resident #3 was admitted to the facility on August 12, 2013, with diagnoses including Septic Left Knee, Type II Diabetes Mellitus, and Pain.

- Medical record review of a Controlled Substance record revealed on August 30, 2013, at 5:00 p.m., a discrepancy of four Oxycodone-Acetaminophen (controlled substance) 10/325 mg (milligram).

- Interview with Licensed Practical Nurse (LPN) #5 on October 10, 2013, at 2:43 p.m., revealed a narcotic count of the controlled substances was

---

**Disclaimer:**

Corrective action response does not constitute agreement with survey findings.

1. Facility will conduct 11/29/13

   - Audit by Nov. 29, 2013 of all residents who were receiving narcotic medication, having the potential to be affected by the same deficient practice, during the time frame that LPN #2 was employed.

2. The corrective action 12/05/13

   - That will be taken, for any resident found to be subject to drug diversion, by LPN #2, will be to notify and reimburse them for the cost of medications diverted.
F 226 | Continued From page 1

3. Facility will ensure that misappropriation of resident's property does not occur again by:

a) in servicing all staff on abuse and neglect policy and procedure by 11/29/13 and to all staff upon hire and annually.
b) conducting weekly audit of narcotic books.
c) Requesting weekly narcotic manifest from pharmacy for audit.
d) Monthly pharmacy audits will continue to be conducted.


Interview with LPN #5 on October 10, 2013, at 2:43 p.m., revealed a narcotic count of the controlled substances was completed after LPN #2 was suspended on August 30, 2013, and the controlled substance record of resident #5 revealed twenty-six Clonazepam 0.5 mg but only twenty-five was available.

Resident #6 was admitted on June 13, 2013, with diagnoses including Cerebrovascular Accident, Left Hemiparesis, Sleep Apnea, and Macular Degeneration.

Medical record review of a Controlled Substance record revealed on August 30, 2013, at 6:50 p.m., a discrepancy of two Hydrocodone-Acetaminophen 5/500 mg.

Interview with LPN #5 on October 10, 2013, at 2:43 p.m., revealed a narcotic count of the controlled substances was completed after LPN #2 was suspended on August 30, 2013, and the controlled substance record of resident #5 revealed twenty-six Clonazepam 0.5 mg but only twenty-five was available.

Resident #6 was admitted on June 13, 2013, with diagnoses including Cerebrovascular Accident, Left Hemiparesis, Sleep Apnea, and Macular Degeneration.

Medical record review of a Controlled Substance record revealed on August 30, 2013, at 6:50 p.m., a discrepancy of two Hydrocodone-Acetaminophen 5/500 mg.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>X1 PROVIDER/SUPPLIER IDENTIFICATION NUMBER</th>
<th>X2 MULTIPLE CONSTRUCTION</th>
<th>X3 DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>445508</td>
<td>A. BUILDING</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>B. WING</td>
<td>10/21/2013</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

GOOD SAMARITAN SOCIETY - FAIRFIELD GLADE

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

100 SAMARITAN WAY
CROSSVILLE, TN 38558

<table>
<thead>
<tr>
<th>X4 ID</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>X5 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEG IDENTIFYING INFORMATION)</th>
<th>X6 ID PREFIX</th>
<th>TAG</th>
<th>X7 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>X8 COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**F 226: Continued From page 2**

#2 was suspended on August 30, 2013.

Continued interview confirmed LPN #5 and RN #1 had counted the narcotics and the controlled substance record of resident #8 confirmed eleven Hydrocodone-Acetaminophen 5/600 mg, and the resident denied administration of two Hydrocodone on August 30, 2013.

Interview with the Director of Nursing (DON), on October 10, 2013, at 3:00 p.m., in the DON Office, confirmed resident #3 was missing four Oxycodeone-Acetaminophen 10/325 mg, resident #5 was missing one Clonazepam 0.5 mg, and resident #8 was missing two Hydrocodone-Acetaminophen 5/600 mg on August 30, 2013, at 5:50 p.m.

Review of facility policy, Missing/Diversion of Medications, dated March 2011 revealed "...The center...will pay for replacement of the missing medication to the payor source...."

Interview with the Administrator on October 10, 2013, at 3:15 p.m., in the DON's Office confirmed the Administrator had knowledge of the missing narcotics. Continued interview confirmed the facility had failed to follow facility policy and had failed to reimburse the residents for a known drug diversion.

**C/O #32622**

F 272 (483.20(b)(1)) COMPREHENSIVE ASSESSMENTS

The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.

1. All staff were in Serviced on GSS elopement policy and procedure on 11/06/13.

4. For this corrective action Narcotic count will be done at every shift change.

Narcotic count sheets will be crossed referenced with pharmacy manifest weekly x 4, Monthly x2 then quarterly.

Pharmacy consultant audits will continue monthly. These will be reviewed at our monthly QA &A meetings to ensure the incident will not recur.
A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:
- Identification and demographic information;
- Customary routines;
- Cognitive patterns;
- Communication;
- Vision;
- Mood and behavior patterns;
- Psychosocial well-being;
- Physical functioning and structural problems;
- Continence;
- Disease diagnosis and health conditions;
- Dental and nutritional status;
- Skin conditions;
- Activity pursuit;
- Medications;
- Special treatments and procedures;
- Discharge potential;
- Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and
- Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:
- Based on medical record review, review of facility documentation, review of facility policy, observation, and interview, the facility failed to
F.272  Continued From page 4

complete an elopement assessment on one resident (#1) of five residents reviewed.

The findings included:

Resident #1 was admitted to the facility on June 24, 2013, with diagnoses including Pneumonia, Alzheimer's Disease, Macular Degeneration, Chronic Kidney Disease, and Depression.

Medical record review of the admission Minimum Data Set (MDS) dated July 1, 2013, revealed the resident had severe cognitive impairment, no wandering, and required extensive assistance for locomotion off unit.

Review of facility documentation dated July 9, 2013, revealed the resident ambulated with a rolling walker and exited the front doors approximately five feet.

Review of the medical record revealed no elopement assessment on admission was completed.

Review of facility policy, Elopement, revised July 2008 revealed "...All residents will be assessed for risk of elopement through the pre-admission and/or admission process..."

Observation on October 10, 2013, at 9:15 a.m., in the Dining Room revealed the resident sitting on the couch with a rolling walker in front of the resident. Continued observation revealed a wanderguard bracelet in place.

Interview with Registered Nurse (RN) #2 on October 10, 2013, at 1:23 p.m., in the Director of Nursing's (DON) Office, revealed no elopement

2 Interdisciplinary team evaluated resident #1 for risk of elopement per GSS policy and procedure. Team determined that resident #1 was at risk for elopement and care plan reviewed and updated. Alarm system for all unit doors have been installed.

3 All residents will be assessed for elopement risk by the interdisciplinary team by 11/29/13. Care plans will be updated if needed.

4 All new residents will be assessed per the GSS Pre Admission Data Collection tool for risk of elopement. If resident is found to be at risk for
F 272: Continued From page 5
assessment had been completed for resident #1.

Interview with the on October 10, 2013, at 1:25
p.m., in the DON's Office confirmed the facility
had failed to assess the resident on admission for
elopement and the resident exited the building.

C/O #32059

5 DNS or designee will
audit all admissions
to ensure all potential
elopement risks have
appropriate care plan
interventions weekly
x 4, monthly x 2 and
quarterly x 4.