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<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X6) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 164 Ss=d</td>
<td>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</td>
<td>F 164</td>
<td>483.10(e), 483.75(l)(4) Personal Privacy/confidentiality of records.</td>
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<tr>
<td></td>
<td>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</td>
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<td></td>
<td>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</td>
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<td>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</td>
<td></td>
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<td></td>
<td>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</td>
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<td></td>
<td>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another health care institution; law; third party payment contract; or the resident.</td>
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<tr>
<td></td>
<td>This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined 1 of 3 (Nurse #1) nurses failed to ensure privacy of residents' was maintained during medication administration.</td>
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LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Signature

DATE: 1-30-14

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 required to continued program participation.
F 164  Continued From page 1

Review of the facility's "Patient Rights" policy documented, "...Nursing home patients have the right to privacy..."

Observations in Resident #119's room on 1/8/14 at 9:30 AM, Nurse #1 administered Resident #119's medications through the Percutaneous Endoscopy Gastrostomy (PEG) tube with the window curtains open. The resident could be seen by anyone that walked by the window.

During an interview in the classroom on 1/9/14 at 1:45 PM, the Director of Nursing (DON) was asked if it was appropriate for the window curtains to be left open during PEG medication administration. The DON confirmed the curtains should not be open.

F 253  483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:
Based on policy review, observation and interview, it was determined the facility failed to ensure the environment was clean, sanitary and orderly as evidenced by dirty air filter, dirty baseboards, dirty commodes, dirty floors, walls and sinks, leaky faucet, cracked caulking, torn plaster, window curtains torn and hanging down off the rod, privacy curtains hanging loosely and missing hooks from the rods and/or broken toilet paper holder in 14 of 52 (Rooms 104, 305, 306, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264).

Corrective Action:
1. An in-service was done with the staff on 1-9-14. On 1-15-2014 during the facility's monthly in-service staff was in-serviced on privacy, dignity and confidentiality by the Director of Nursing and staff coordinator.
2. On 1-10-14 the Administrator did a facility audit to check to ensure that each room had a working, clean privacy curtain for each resident.
3. Administrator, Director of Nursing and Assistant Director of Nursing will make random audits during the work week and after hour visits to check for compliance with privacy curtains.
4. The Q.A. Committee, consisting of Medical Director, Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON), MDS Coordinator, Staffing Coordinator, Dietary, Social, Activity Coordinator will monitor for compliance through review of facility rounds and documented audits for three months. If compliance is not met, the facility staff will be re-in-serviced and audits will continue until substantial compliance is met.
Completed by 1/10/2014

F 253  483.15(h)(2) Housekeeping & Maintenance Services

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

Corrective Action:
1. On 01/08/14 all air filters were cleaned, and all curtain hooks were replaced or hung back on the rods. On 1/09/14 all corners were cleaned, toilets and walls were cleaned. On 01/12/14, all caulking around toilets were removed and replaced with new caulking.
F 253 Continued From page 2

The findings included:

1. Review of the facility's "Housekeeping Outline (Job Responsibility)" documented, "...Housekeepers should then begin... doing a complete... Specific areas to be cleaned are: doors and door frames; walls and ceilings where dust accumulates; patient room furniture; windows; window tracks; window sills... and all bath fixtures..."

Review of the facility's "Detailed Room Inspection" policy documented, "...The following items should be inspected and repaired as necessary... Bathroom floor cover base, walls, ceilings-paint, repair or replace. Commodes... Walls-clean, no holes, painted, in good repair... Curtains-clean, in good repair, open and close easily..."

2. Observations in room 104 on 1/6/14 at 3:25 PM, revealed the air conditioner unit's filter had a thick gray matter that rolled and fell off onto the floor.

3. Observations in room 305 on 1/5/14 at 10:00 AM, revealed a dark brown dried substance on the bathroom basinboards and the bottom portion of the commode.

4. Observations in room 306 on 1/6/14 at 3:20 PM and on 1/7/14 at 8:45 AM, revealed the bathroom floor was dirty and had a buildup of dirt in the corners, the sink faucet was leaking, the top edge of the sink was dirty with cracked caulking around the sink, the walls were dirty and F253 continued:
The broken toilet paper holder was replaced. On 1/13/14 all window tracks and sills were cleaned, and leaking faucet was replaced.

2. On 01/09/14 the Administrator and Maintenance Man made rounds through out the building doing a full building audit on the rooms. The housekeeping and floor tech responsibilities were updated and charged to fit the current job duties. The environmental staff was in-served on their job duties. On 01/19/14 the environmental staff had to sign a new job duties sheet. On 01/16/14 the Administrator and Maintenance Man made rounds to check for compliance.

3. The Administrator and Maintenance Man will make routine rounds and audits to check for compliance.
   a. Filters will be cleaned bi-weekly instead of monthly.
   b. We will detail 5 rooms a month.
   c. The baseboards and repair in the mentioned rooms, and an audit was completed on the building for the next 5 rooms.
   d. Torn curtains were replaced. We are in the process of changing the curtains out for blinds to decrease the use of cloths products and patient tying the curtains in knots.
   e. We will make daily rounds to check the curtains to ensure the curtains are hanging correctly.
   f. All rooms were checked to make sure the toilets, corners, and walls were clean.
   g. Pest control came out on 01/09/2014 and sprayed for pest.
4. The Q.A. Committee, consisting of Medical Director, Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON), MDS Coordinator, Staffing Coordinator, Dietary, Social, Activity Coordinator will monitor for compliance through review of facility rounds and documented audits for three months. If compliance is not met, the facility staff will be retrained and audits will continue until substantial compliance is met.

Completed by 1/16/2014
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<th>F 253 Continuation from page 3</th>
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<td>stained and in the bedroom the plaster was torn off the corner of the wall under the television.</td>
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5. Observations in room 307 on 1/6/14 at 11:30 AM, revealed the window curtain was hanging down from the rod and held together with a clothespin. On 1/7/14 at 8:10 AM and on 1/8/14 at 8:00 AM, revealed the window curtain was torn along the bottom with threads hanging down and hanging loosely from the top rod missing hangers and held together with a clothespin and the privacy curtain between the beds was hanging loose from the rod.

6. Observations in room 309 on 1/6/14 at 11:33 AM on 1/7/14 at 8:18 AM, revealed the privacy curtain between the beds hanging down from the top rail, the curtain over the window was hanging down from the rod. The bathroom had dirt around the wall, and grime buildup in the corners of the floor and missing cove base with a hole in the sheet rock, the wall behind the commode was dirty with dried streaks running down the wall.

7. Observations in room 311 on 1/7/14 at 8:30 AM, revealed the floor under the air conditioner unit was dirty with dust, dirt and grime, the window curtain was pulled and closed with a clothespin, the bathroom floor had dirt and grime buildup around the edges and the walls were dirty with dried streaks. On 1/8/14 at 9:45 AM, the privacy curtain between the beds was dirty with spots of brown stain.

8. Observations in room 314 on 1/7/14 at 8:50 AM, revealed dirt and grime along the edges of the floor in the bathroom, the cove base behind the commode was dirty, there was a dirt sediment on top of the vanity sink, dirt along the top of the
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<th>(x2) PROVIDER/Supplier/CIA IDENTIFICATION NUMBER:</th>
<th>445330</th>
<th>(x2) MULTIPLE CONSTRUCTION A. BUILDING</th>
<th>(x3) DATE SURVEY COMPLETED</th>
<th>01/09/2014</th>
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Continued From page 4

vanity and a dirt buildup and grime in the corners of the bathroom floor.

9. Observations in room 315 on 1/6/14 at 11:45 AM, revealed the window curtains were hanging from the rod, the privacy curtain between the beds was missing several hooks, the wood trim under the window was dirty and covered in dust, dirt along the wall on the floor and in the corner, the bathroom floor along the wall behind the commode was dirty, the floor tile was buckled and not laying flat, the floor was stained between the commode and the wall under the tissue holder, dead bugs in the room, the wall under the sink and behind the commode was dirty with a spider web with a live spider crawling in the web, the floor has dirt in the corners.

10. Observations in room 401 on 1/6/14 at 9:47 AM, revealed the top of the window curtains were loose and hanging disheveled from the rod.

11. Observations in room 402 on 1/6/14 at 9:50 AM, revealed the privacy curtain in the center of the room was off the hooks in places.

12. Observations in room 406 on 1/7/14 at 1:45 PM, revealed the bathroom floor was dirty.

13. Observations in room 407 on 1/7/14 at 9:42 AM, revealed the window curtains were loose and hanging disheveled from the curtain rod.

14. Observations in room 408 on 1/6/14 at 3:31 PM, revealed dirt and bugs in the corner of the room by the window, the toilet paper holder in the bathroom was broken, a hole in the wall below a pipe under the sink with a water mark down the wall to the floor and the bathroom floor was dirty.
15. Observations in room 411 on 1/6/14 at 10:05 AM and on 1/7/14 at 10:00 AM, revealed the window curtains were loose and hanging disheveled from the curtain rod.

16. During an interview in room 311 on 1/8/14 at 9:45 AM, the Administrator and the Maintenance Supervisor confirmed the dirt and grime buildup were not acceptable. Both were asked why the window curtains were held together with clothespins. The Maintenance Supervisor stated, "[Names a resident] doesn't like for the curtains to blow out over the fan..." The Maintenance Supervisor was then asked if [named a resident] put clothespins on the other resident's curtains. The Maintenance Supervisor then stated, "...I don't know why the others have the [clothespins],... these curtains are cheap plastic and we are forever putting them back on the rods..."

During an interview in the Administrator's office on 1/8/14 at 10:45 AM, the Administrator and the Maintenance Supervisor both agreed that there should not be spiders and cobwebs and base boards with dark brown dried substance in residents' rooms.

483.20(g) - (i) 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.
F 278 Continued from page 6
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 medical record review and interview, it was determined the facility failed to accurately assess a resident for Clostridium Difficile, Septic Syndrome and Post Operative Surgical Hip Fracture for 1 of 17 (Resident #121) sampled residents of the 28 residents included in the stage 2 review.

The findings included:
Medical record review for Resident #121 documented an admission date of 10/14/13 and a readmission date of 11/1/13 with diagnoses of Clostridium Difficile (C-Diff) Enterocolitis, Septic Syndrome, Status Post (S/P) Left Hip.

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.

Plan of Correction:
1. Care plan for Resident #121 was corrected. MDS coordinators were in-serviced on documentation of care plan on 01/10/2014. Nurses were in-serviced on 01/15/2014 on accurate charting on the 24 hour care plan.
2. A chart review was completed on 01/15/2014 to ensure that care plans were updated, complete and accurate assessment reflective of resident’s status at the present time.
3. The Administrator, DON, ADON, will do random audits of the charts for accurate and complete assessment of the MDS and care plans.
4. The Q.A. Committee, consisting of Medical Director, Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON). MDS Coordinator, Staffing Coordinator, Dietary, Social, Activity Coordinator will monitor for compliance through review of facility rounds and documented audits for three months. If compliance is not met, the facility staff will be re-in-serviced and audits will continue until substantial compliance is met.
Completed by 1/15/2014
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<th>F 278</th>
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<td>Hemiarthroplasty, Anemia, Hypertension, and Diabetes Mellitus. Review of a physician's order dated 11/1/13 documented, &quot;...Contact Isolation for C-Diff...&quot; Review of a physician progress note dated 11/1/13 documented, &quot;...Admitted to SNF [skilled nursing facility]... Dx [diagnosis] C-Diff Septic Synd [syndrome] s/p L hip hemi (Hemiarthroplasty)...&quot; Review of the 5 day Minimum Data Set (MDS) with an assessment review date of 11/8/13 for Resident #121 revealed no documentation of the admitting diagnoses of Clostridium Difficile, Septic Syndrome or the Post Surgical Hip Fracture.</td>
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<td>During an interview in the MDS office on 11/8/14 at 5:45 PM, MDS Nurse #1 was asked if Resident #121's MDS documented the admitting diagnoses of C-Diff, Sepsis or the Post Op Hip Fracture. MDS Nurse #1 stated, &quot;No, not where you want to see it...&quot; MDS Nurse #1 was then asked if these diagnoses should be on the MDS. MDS Nurse #1 stated, &quot;Yeah probably...&quot;</td>
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<tr>
<th>F 279</th>
<th>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</th>
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<td>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</td>
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<td>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.</td>
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<td>The care plan must describe the services that are to be furnished to attain or maintain the resident's</td>
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**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...
### F 279 - Continued From page 8

**Requirement**: The facility fails to have a care plan for Deep Vein Thrombosis (DVT), Anticoagulant Therapy, Infection of a Post Operative Wound, Clostridium Difficile (C-Diff), Isolation and/or Post Operative Hip for 2 of 17 Residents #116 and 121 sampled residents of the 28 residents included in the stage 2 review.

**Corrective Action**:
- Care plans for Resident #116 & #121 were corrected.
- MOS coordinator was in-serviced on documentation of care plan on 01/10/2014.
- Nurses were in-serviced on 01/15/2014 on accurate charting on the 24 hour care plan.
- A chart review was completed on 01/15/2014 to ensure that care plans were updated, complete, and accurate assessment reflective of resident's status at the present time.
- The Administrator, DON, ADON, will do random audits of the charts for accurate and complete assessment of the MDS and care plans.
- The Q.A. Committee, consisting of Medical Director, Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON). MOS Coordinator, Staffing Coordinator, Dietary, Social, Activity Coordinator will monitor for compliance through review of facility rounds and documented audits for three months. If compliance is not met, the facility staff will be re-in-serviced and audits will continue until substantial compliance is met.

Completed by 1/15/2014
Continued From page 9  

psychological wellbeing... Care Plans For Anticoagulants For patient receiving anticoagulant therapy, the reason must be listed under the care plan problem and goal..."


During an interview in the classroom on 1/9/14 at 1:40 PM, the Director of Nursing (DON) was asked if the admission diagnoses were included on the interim care plan and if they should be. The DON stated, "They are not addressed... the admission diagnoses should be addressed. Yes ma'am..." The DON confirmed the date of the admission care plan was incorrect and should be dated 11/8/13.

3. Medical record review for Resident #121
| F 279 | Continued From page 10 documented an admission date of 10/14/13 and a readmission date of 11/1/13 with diagnoses of Clostridium Difficile Enterocolitis, Septic Syndrome, S/P Left Hip Hemiarthroplasty, Anemia, Hypertension, and Diabetes Mellitus. Review of a physician's order dated 11/1/13 documented, "...Contact Isolation for C-Diff..." Review of a physician progress note dated 11/1/13 documented, "...Admitted to SNF [Skilled Nursing Facility]... Dx [diagnoses] C-Diff Septic Synd [syndrome] s/p L hip hemi [hemiarthroplasty]..." Review of a physician's order dated 11/1/13 documented, "...Cephalexin 500 mg [milligrams] PO [by mouth] BID [twice a day] x [times] 10 days for incision... Lactinex 2 pkts [packets] PO in H2O [water] TID [three times a day] for C-Diff... Contact Isolation for C-Diff... Vancomycin 250 mg PO QID [four times a day] x 14 days..." Review of the admission care plan dated 11/1/13 documented, "...INFECTION..." left blank. The problems of C-Diff, Isolation and Post Op Wound were not included on the care plan.

During an interview in the Minimum Data Set (MDS) office on 1/8/14 at 3:45 PM, MDS Nurse #1 stated, "...the person who admits the patient does the interim [admission] care plan."

During an interview in the MDS office on 1/8/14 at 3:50 PM, MDS Nurse #1 and Nurse #3 were asked if the care plan should address C-Diff, Isolation and Post Op Wound Incision. MDS Nurse #1 and Nurse #3 both stated, "Yes," as they shook their heads.

| F 280 | 483.20(d)(5), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged
F 280 Continued from page 11
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 ensure the comprehensive care plans were revised to reflect the residents' current status related to falls, a broken humerus in a sling and the discontinuation of treatment since the stage 3 pressure ulcer had healed for 3 of 17 (Residents #20, 42 and 104) sampled residents of the 28 residents included in the stage 2 review.

The findings included:

1. Medical record review for Resident #20 documented an admission date of 4/9/10 and a readmission date of 9/14/13 with diagnoses of Late Effects of Cerebrovascular Accident, Atrial...
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| F 280         | Continued From page 12  
Fibrillation, Parkinson’s Disease, Hypertension, Coronary Artery Disease, Non-organic Psychosis, Gastro Esophageal Reflux Disease, Renal Artery Stenosis, Hallucinations, Decreased Appetite, Cardiomegaly, Tremors, Alzheimer’s Disease, Depression, Hyperlipidemia, Deconditioning Syndrome, Anxiety, Schizoaffective Disorder, Ataxia, and Seizures. The medical record revealed Resident #20 had falls on 2/5/13, 2/15/13, 4/6/13, 4/11/13, 4/25/13, 5/13/13, 5/26/13, 7/8/13, 8/11/13, 8/12/13, 8/19/13, 8/20/13, 8/21/13, 8/22/13, 8/28/13, 10/12/13, and 12/19/13. Review of the care plan dated 9/20/13 revealed the interventions for the falls which occurred on 4/25/13, 5/26/13, 7/8/13, 8/20/13, 10/12/13, and 12/19/13 were interventions that had already been put into place and were not new interventions.  
During an interview in the minimum data set (MDS) office on 1/14 at 12:50 PM, MDS Nurse #2 was asked about the resident’s falls and lack of new interventions on the care plans. MDS Nurse #2 confirmed the interventions on the care plan for 4/25/13, 5/26/13, 7/8/13, 8/20/13, 10/12/13 and 12/19/13 were interventions that had already been used and were not new interventions.  
2. Medical record review for Resident #42 documented an admission date of 9/12/13 with diagnoses of Congestive Heart Failure, Pleural Effusion, Aftercare Trauma Fracture Vertebrae, Aftercare Trauma Fracture Low Armhead Injury, Hypertension, Muscle Weakness, Anorexia, Atrial Fibrillation, Osteoporosis, and Diabetes Type II. Nurses notes dated 12/14/13 documented “…Unobserved… C/O [complained of] pain to the L [left] upper arm with swelling and decreased...
Continued from page 13:

mobility... Transferred to hospital? Yes... [named hospital] Mode of Transportation: Ambulance..." Review of the care plan dated 9/30/13 revealed no documentation of the humerus fracture or aftercare with a sling.

Observations in Resident #42's room on 1/6/14 at 3:14 PM, on 1/7/14 at 7:51 AM and 5:38 PM and on 1/8/14 at 1:52 PM, revealed Resident #42 wearing a sling on her left arm.

During an interview in the Director of Nursing's (DON) office on 1/8/14 at 11:41 AM, the MDS Nurse #1 coordinator stated, "Shoulder and sling not on care plan. Had to be oversight. I knew she had fracture and sling..."

During and interview in the DON's office on 1/8/14 at 1:35 PM, the DON was asked if she expected the injury and treatment with the sling to be on the care plan. The DON stated, "Yes."


During an interview in the MDS office on 1/8/14 at 8:10 AM, the MDS nurses were asked where the documentation was for the stage 3 pressure ulcer listed on the care plan. MDS Nurse #2 stated, "She [Resident #104] went in and out of the hospital several times..." MDS Nurse #1 stated,
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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**STREET ADDRESS, CITY, STATE, ZIP CODE**
765 BERT JOHNSTON AVE P O BOX 544
COVINGTON, TN 38019

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<td>F 280</td>
<td>Continued from page 14 &quot;She originally did have a stage 3 on her sacral area, it [care plan] should probably have said history of stage 3 [pressure ulcer]...&quot; The MDS nurses were asked if this was an inaccurate care plan. MDS Nurse #1 stated, &quot;Yes, she remains at high risk...&quot;</td>
<td>F 280</td>
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<td>F 282</td>
<td>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</td>
<td>F 282</td>
<td>483.20(k)(3)(ii) Services by qualified Persons/Per care plan. The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Corrective Action: 1. I &amp; O care plan was corrected to show there was not need to monitor I &amp; O's on resident #104. MDS Coordinator was instructed on importance of reviewing each intervention to ensure it was individualized to resident. 2. A chart review was completed on 01/15/2014 to ensure that care plans were updated, complete and accurate assessment reflective of resident's status at the present time. 3. The Administrator, DON, ADON, will do random audits of the charts for accurate and complete assessment of the MDS and care plan. 4. The Q.A. Committee, consisting of Medical Director, Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON), MDS Coordinator, Staffing Coordinator, Diet, Social, Activity Coordinator will monitor for compliance through review of facility rounds and documented audits for three months. If compliance is not met, the facility staff will be reinserviced and audits will continue until substantial compliance is met. Completed by 1/15/2014</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 follow the care plan interventions for measuring Intake and output (I&O) for 1 of 17 (Resident #104) sampled residents of the 28 residents included in the stage 2 review.

The findings included:

Medical record review for Resident #104 documented an admission date of 11/15/2013 with diagnoses of Cellulitis, Gangrene, Atrial Fibrillation, End Stage Renal Disease, Diabetes, Encephalopathy, Anemia, Muscle Weakness, Status Post Below Knee Amputation, Acute Kidney Failure, Gastrointestinal Hemorrhage and Hypertension. Review of the care plan dated 12/29/13 documented, "...Problems... At risk for complications of renal failure... Interventions... I&O's... Status: Active..."
F 282

Continued From page 15

During an interview in the Director of Nursing's (DON) office on 1/8/14 at 1:30 PM, the Assistant Director of Nursing (ADON) was asked about I&O monitoring and documentation. The ADON stated, "...they [I&O's] are not on the TAR [Treatment Administration Record] for December [2013]... She [Resident #104] does not have an order for I&O's on this admission and it's [the order] not in the computer..."

During an interview in the MDS office on 1/8/14 at 2:00 PM, the minimum data set (MDS) Nurse #2 was asked about the I&O intervention on the care plan. MDS Nurse #2 stated, "...it was a generic standard and I just didn't remove it [from the care plan]..."

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 policy review, medical record review, observation and interview, it was determined the facility failed to ensure there was a physician’s order for a sling for a resident with a fractured humerus and failed to provide adequate nutrition for a dialysis resident for 2 of 17 (Residents #42 and #104) sampled residents of the 29 residents included in the stage 2 review.
**F 309** Continued From page 16

The findings included:

1. Review of the facility's "Physician's Orders" policy documented, "Must have SPECIFIC physician orders for the following areas: "...d. Special treatments (pressure ulcer or other wound care, soaks, heat or cold applications, Foley catheter...)"

Medical record review for Resident #42 revealed an admission date of 9/12/13 with diagnoses of Congestive Heart Failure, Pleural Effusion, Aftercare Trauma Fracture Vertebrae, Aftercare Trauma Fracture Low Arm Injury, Hypertension, Muscle Weakness, Anorexia, Atrial Fibrillation, Osteoporosis and Diabetes Type II. Review of the nurses notes dated 12/4/13 documented "...Unobserved... C/O [complained of] pain to the L [Left] upper arm with swelling and decreased mobility... Transferred to hospital? Yes... [named hospital] Mode of Transportation: Ambulance..." There was no physician's order for the sling Resident #42 was wearing.

Observations in Resident #42's room on 1/6/14 at 3:14 PM, on 1/7/14 at 7:51 AM and 5:38 PM, and on 1/8/14 at 4:52 PM, revealed Resident #42 wearing a sling on her left arm.

During an interview in the Director of Nursing's office on 1/8/14 at 11:45 AM, the DON was asked whether there was a physician's order for Resident #42's sling. The DON stated, "...Could not find one..."

2. Review of the facility's "NUTRITIONAL SERVICES" policy documented, "A qualified dietitian oversees the clinical nutritional dietary
Continued From page 17

services in the facility... who is responsible for... a nutrition care process to meet the needs of patients for health maintenance...

Medical record review for Resident #104 documented an admission date of 11/15/2013 with diagnoses of Cellulitis, Gangrene, Atrial Fibrillation, End Stage Renal Disease, Diabetes, Encephalopathy, Anemia, Muscle Weakness, Status Post Below Knee Amputation, Acute Kidney Failure, Gastrointestinal Hemorrhage and Hypertension. Review of the care plan dated 12/29/13 documented, "...Problems... Weight loss... Interventions... Monitor food intake at each meal... supervise... while [named Resident #104] has food/supplements/snacks..."

During an interview in the 100 hall on 1/8/14 at 9:00 AM, Nurse #2 was asked what is the procedure for sending Resident #104 out for dialysis. Nurse #2 stated, "I document weight, vitals done... she [Resident #104] is usually gone from 9:15 [AM] or so until about 3:15 [PM]..." Nurse #2 was asked if the resident is to have a snack or lunch sent with them to dialysis. Nurse #2 stated, "I don't know... I personally did not send a snack with her yesterday..."

During an interview in the dining room on 1/8/14 at 11:30 AM, Resident #104 was asked if she gets hungry on dialysis days. Resident #104 stated, "Yes, but the dialysis place won't let anybody eat there."

During an interview in the Director of Nursing's (DON) office on 1/8/14 at 1:30 PM, the Assistant Director of Nursing (ADON) was asked about sending snacks or lunch with residents going to dialysis. The ADON stated, "We have just started..."
Continued from page 18

F 309
Doing business with this clinic... We are going to get with the dialysis clinic and develop a better relationship...[named staff member] will be brought in to have a system and a plan in place to make sure the [Resident #104] is taken care of..."

F 431
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 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...
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION
(X1) PROVIDER/SUPPLIER/LICA
IDENTIFICATION NUMBER:
445330

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
01/09/2014

NAME OF PROVIDER OR SUPPLIER
COVINGTON CARE NURSING & REHABILITATION CENTER INC

STREET ADDRESS, CITY, STATE, ZIP CODE
765 DEPT JOHNSON AVE P O BOX 544
COVINGTON, TN 38019

(X4) ID PREFIX TAG
F 431

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LIC IDENTIFYING INFORMATION)

F 431 Continued From page 19
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 interview, it was determined the facility failed to ensure medications were stored properly in 2 of 4 (100 and 300 hall medication carts) medication storage areas.

The findings included:
1. Review of the facility's medication storage policy documented, "...medications must be properly stored in medication rooms or medication carts..."

2. Observations on the 100 hall on 1/8/14 at 11:35 AM, revealed loose pills in the second drawer of the 100 hall medication cart. Nurse #1 confirmed the pills should not be loose in the drawer.

3. Observations on the 300 hall on 1/8/14 9:32 AM, revealed a loose pill in the third drawer of the 300 hall medication cart. Nurse #4 confirmed the pill should not be loose in the drawer.

(X5) ID PREFIX TAG
F 456

F 431 continued from page 19
Corrective Action:
1. The loose pills were removed and sent to be destroyed in 100 hall and 300 hall medication carts on 1/8/2014. The nurses were in-serviced on the correct storage of medication.

2. The nurses were in-serviced again on 1-15-2014 at the monthly in-serviced. The DON and ADON completed an audit of all medication carts on 01/09/2014 for compliance.

3. The DON and ADON will make random audits of the medication carts weekly for 4 weeks, then do monthly until we are in compliance.

4. The Q.A. Committee, consisting of Medical Director, Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON). MDS Coordinator, Staffing Coordinator, Dietary, Social, Activity Coordinator will monitor for compliance through review of facility rounds and documented audits for three months. If compliance is not met, the facility staff will be re-in-serviced and audits will continue until substantial compliance is met.

Completed by 1/15/2014

F 456

F 465
483.70(h)
Safe/Functional/Sanitary/Comfortable Environment
The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.
This REQUIREMENT is not met as evidenced by:
Based on policy review, observation and interview, it was determined the facility failed to ensure 1 of 2 (300 hall common bath/shower room) was maintained in a clean, safe and sanitary manner.

The findings included:
Review of the facility's "Detailed Room Inspection" policy documented, "...the following items should be inspected and repaired, as necessary. 1. Bathroom floor, cove base walls, ceilings-paint, repair or replace. 2. Commodes - grout... 3. Sinks/ Vanities - faucet appearance, chips... 8. Floor tile, cove base, corner guards - in good repair... 9. Walls - clean, no holes, painted, in good repair... Curtains - clean, in good repair..."

Review of the facility's housekeeping job responsibility policy documented, "...5. Specific common areas... exhaust vents; or any item that is prone to dust collection..."

Observations in the 300 hall common bath/shower room on 1/6/14 at 12:00 PM, revealed walls were scuffed, the floor was dirty, there was a brown substance smeared on the wall plaster, tile was missing across the floor threshold between the entry door and the shower, grout in the shower and on the wall and floor were stained black, a shower curtain had black stains on the inside and torn across the bottom, the floor along the whirlpool was stained and dirty, the floor was missing a tile with a rusty nail sticking up, the training toilet floor was dirty along the walls and the walls were scuffed and had 3 holes.
Continued From page 21

in the wall beside the sink.

Observations in the 300 hall common
bath/shower room on 1/8/14 at 9:30 AM, revealed
dirty tissue on the shower floor, a brown smear
on the wall with several black scuff marks, the
entry floor had dark dirty stains, there was
missing tile beside the whirlpool, used toilet tissue
on the floor beside the whirlpool, a plastic coat
hanger was on the floor, a piece of equipment
plugged in the wall was laying on the floor and
trash on the floor.

During an interview in the 300 hall common
bath/shower room on 1/8/14 at 9:30 AM, the
Administrator was asked if the dirt on the floors
and walls was acceptable. The Administrator
stated, "No ma'am."

During an interview in the training toilet room on
1/8/14 at 9:35 AM, the Maintenance Supervisor
was asked what the equipment on the floor was
and why were there holes in the wall. The
Maintenance Supervisor stated, "...That is off of
that [indicating a piece of equipment in the
shower room]... the holes in the wall are where
the anchors have pulled out and I was not
aware... Nobody told me... Nursing will put it in
my log at the nurses station..."

483.70(h)(4) MAINTAINS EFFECTIVE PEST
CONTROL PROGRAM

The facility must maintain an effective pest
control program so that the facility is free of pests
and rodents.

483.70(h)(4) Maintains effective Pest Control Program
The facility must maintain an effective pest control program so the
facility is free of pests and rodents.
### F 469

Continued From page 22

This REQUIREMENT is not met as evidenced by:

Based on policy review, observation and interview, it was determined the facility failed to maintain an environment free of pests in 3 of 52 (rooms 108, 315 and 408) resident rooms.

The findings included:

1. Review of the facility's "Pest Control Policy" policy documented, "...The facility will have a monthly inspection and treatment for pest control. The facility will keep a pest sighting log. Staff will log any sighting of pest... Maintenance will check the log and notified [named exterminator]...".

2. Observations in room 108 on 1/8/14 at 9:36 AM, revealed a cockroach above the door frame.

During an interview in room 108 on 1/8/14 at 9:36 AM, Nurse #1 was asked what was above the door. Nurse #1 stated, "Looks like a cockroach to me."

3. Observations in room 315 on 1/8/14 at 11:45 AM, revealed the wall under the sink and behind the commode was a spider web with a live spider crawling in the web.

4. Observations in room 408 on 1/8/14 at 3:31 PM, revealed bugs in the corner of the room by the window.

### F 514

SS=D

483.75(1)(1) RES

RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that

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**F 469 continued from Page 22**

**Corrective Action:**

1. The bug in room 108 and the spider in room 315 was killed and removed from the room on 1/8/2014. The dead bugs from room 408 removed. Pest control came out on 01/09/2014 to spray.

2. Staff was in-service on our pest control log and charting of any site of insects. Pest control will be called out for all insect spotting.

3. The Administrator, Maintenance, floor staff, housekeeping will make random rounds to check for insects.

4. The Q.A. Committee, consisting of Medical Director, Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON). MDS Coordinator, Staffing Coordinator, Dietary, Social, Activity Coordinator will monitor for compliance through review of facility rounds and documented audits for three months. If compliance is not met, the facility staff will be retrained and audits will continue until substantial compliance is met.

Completed by 1/15/2014
F 514 Continued From page 23
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 by:
Based on medical record review, observation and interview, it was determined the facility failed to maintain a complete and readily accessible medical record for 1 of 28 (Resident #42) sampled residents included in stage 2 review.

The findings included:
Review of the facility's medical record and charting policy documented, "...The chart serves as a documentation of the patient's medical history and care and services provided at the facility. The medical record also serves as a basis for planning patient care and documenting communication between the health care providers providing continuity of patient care..."

Medical record review of Resident #42 documented an admission date of 5/12/13 with diagnoses of Congestive Heart Failure, Pleural Effusion, Aftercare Trauma Fracture Vertebrae, Aftercare Trauma Fracture Low Armhead Injury, Hypertension, Muscle Weakness, Anorexia, Atrial Fibrillation, Osteoporosis and Type II Diabetes. Review of the nurses notes dated 12/4/13

F 514 continued from page 23
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.
Corrected Action:

1. Medical Director wrote a order for the sling on resident #2.
The Medical Director had wrote in his notes that she had a sling, but had writing the order. The Care plan was corrected
2. The Administrator, DON, ADON, MDS Coordinator, dietcy manager, and staffing coordinator will monitor residents with going out during meal time, and residents with slings, braces, etc.
3. The DON, ADON, and the Administrator will randomly check charts and care plans for accuracy.
4. The Q.A. Committee, consisting of Medical Director, Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON), MDS Coordinator, Staffing Coordinator, Dietary, Social, Activity Coordinator will monitor for compliance through review of facility rounds and documented audits for three months. If compliance is not met, the facility staff will be retrained and audits will continue until substantial compliance is met.
Completed by 1/15/2014
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<td>F 514</td>
<td>Continued From page 24 documented, &quot;...C/O [complained of] pain to the L [left] upper arm with swelling and decreased mobility... Transferred to hospital? Yes... [named hospital] Mode of Transportation: Ambulance...&quot; The medical record did not include documentation of the results of the hospitalization visit, the care plan did not include information of the fractured humerus with a sling and no documentation of a physician's order for the sling on Resident # 42's left arm. Observations on Resident #42's room on 1/6/14 at 3:14 PM, on 1/7/14 at 7:51 AM and 5:38 PM, and on 1/8/14 at 1:52 PM, revealed Resident #42 wearing a sling on her left arm. During an Interview in the Director of Nursing's office (DON) on 1/8/14 at 11:41 AM, the minimum data set (MDS) nurse coordinator #1 stated, &quot;Shoulder and sling not on care plan. Had to be oversight I knew she had fracture and sling...&quot; During an Interview in the DON's office on 1/8/14 at 11:45 AM, the DON was asked about physician's order for a sling. The DON stated, &quot;Could not find one.&quot; During an interview in classroom on 1/8/14 at 1:50 PM, the DON was asked if she would have expected the hospital report, physician's orders, and the humerus fracture with a sling on the care plan. The DON stated, &quot;Yes.&quot;</td>
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