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<th>ID</th>
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**Summary Statement of Deficiencies**

**F 159 (c)(2)-(5) Facility Management of Personal Funds**

Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(6) of this section.

The facility must deposit any resident's personal funds in excess of $50 in an interest-bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than this resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the account exceeds $50. (9/11/12)

**Providers Plan of Correction**

1. Resident's will have access to personal funds. Access to personal funds will be maintained to all residents residing in the facility that have a resident trust fund.

2. Resident #25 and resident #33 have been informed of the process implemented by the facility to ensure residents access to funds after hours. Facility will call a resident council meeting to explain the new process of obtaining funds after hours. The process will be explained by the Business Office Manager and Administrator. (9/7/12)

3. Any resident needing or wanting access to his/her funds after hours has the potential to be affected by alleged deficient practice. The facility has developed a procedure to ensure residents access to their funds.

**Laboratory Director's or Provider/Supplier Representative's Signature**

**Date**

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 patient. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 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.

**Date of receipt**

**Facility ID:** TN0022

**Event ID:** TW0011

If continuation sheet Page 1 of 25
<table>
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<tr>
<th>ID</th>
<th>PRE-TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LIC IDENTIFYING INFORMATION)</th>
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<td>F 159</td>
<td>Continued From page 1 residents account reaches $200 less than the SSI resource limit for one person, specified in section 1911(e)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</td>
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This REQUIREMENT is not met as evidenced by:
- Based on policy review and interview, it was determined the facility failed to ensure residents had access to personal funds on the weekend for 2 of 14 (Residents #25 and 33) residents interviewed during the stage 1 resident interviews.

The findings included:

1. Review of the facility’s, "Business Office Guidelines" policy documented, "...16. The person handling the resident trust fund accounts will have access to the trust box at all times, NO other facility personnel will have access..."  

2. During an interview in Resident #25’s room on 8/20/12 at 11:36 AM, Resident #25 was asked, "Do you have a personal funds account with the facility?" Resident #25 stated, 'Yes.' Resident #25 was then asked, "Can you get your money when you need it, including on weekends?" Resident #25 stated, "I don’t think you can get it on weekends. I have to get it Friday for the weekend."

3. During an interview in Resident #33’s room on 8/20/12 at 2:01 PM, Resident #33 was asked, "Do Continued From pg. 1 personal funds after hours. All licensed staff have been in-serviced on the process pertaining to residents funds.(9/7/12)  

4. Facility developed new procedure to ensure residents have access to their money after hours i.e.; charge nurse for the West hall will have a copy of the facility trial balance from the Resident Fund Management System. Withdrawal forms will be available and a log kept of withdrawals. Licensed staff has been trained on resident funds and resident rights to access funds. Staff members have been in-serviced on new processes and residents rights to personal funds.(9/7/12)
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<thead>
<tr>
<th>ID</th>
<th>NAME OF PROVIDER OR SUPPLIER</th>
<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
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<tr>
<td>F159</td>
<td>HILLVIEW COMMUNITY LIVING CENTER</td>
<td>697 EVERGREEN STREET, PO BOX 769 DRESDEN, TN 38225</td>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>F159</td>
<td>F159 Continued From page 2 you have a personal funds account with the facility?&quot; Resident #33 stated, &quot;Yes.&quot; Resident #33 was then asked, &quot;Can you get your money when you need it, including on weekends?&quot; Resident #33 stated, &quot;Can get my money Monday through Friday.&quot; 4. During an interview in the business office on 8/22/12 at 9:30 AM, the business office manager was asked to explain how the residents get money from their petty cash. The business office manager stated, &quot;...they [residents] get it from me...&quot; The business office manager was asked if the residents can get their money on the weekend. The business office manager stated, &quot;...most of them know to get it early... if something comes up they can call me... I only live about a 1/2 mile away... nurses are good about giving the residents money for a coke... they [nurses] leave me a note and I refund their money...&quot; 5. During an interview in the business office on 8/22/12 at 10:30 AM, the Administrator was asked how residents would get their money on the weekend if the business officer manager was unavailable. The Administrator stated, &quot;...I am the business office manager's back-up... if the resident needed money I would come in... live about 20 minutes away... nurses good about giving the residents money and then they get reimbursed... nurses do not know how much money the residents have or even if they have an account...&quot;</td>
<td>F159 Continued From pg.2 5.) Activity Director/Designee will interview resident council monthly to ensure residents are able to obtain funds after hours. Activity Director/Designee will interview 2 residents at random monthly for 3 months to ensure they are aware of their ability to withdraw money after hours. Any issues discovered will be reported to the QA/QI committee for follow-up.</td>
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<tr>
<td>F272</td>
<td>483.20(b)(1) The facility must conduct initially and periodically</td>
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Event ID: TW03111 Facility ID: TH0202
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<th>TAG</th>
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<td>F272</td>
<td>272</td>
<td><strong>A comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</strong>&lt;br&gt;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:&lt;br&gt;- Identification and demographic information;&lt;br&gt;- Customary routine;&lt;br&gt;- Cognitive patterns;&lt;br&gt;- Communication;&lt;br&gt;- Vision;&lt;br&gt;- Mood and behavior patterns;&lt;br&gt;- Psychosocial well-being;&lt;br&gt;- Physical functioning and structural problems;&lt;br&gt;- Continence;&lt;br&gt;- Disease diagnosis and health conditions;&lt;br&gt;- Dental and nutritional status;&lt;br&gt;- Skin conditions;&lt;br&gt;- Activity pursuit;&lt;br&gt;- Medications;&lt;br&gt;- Special treatments and procedures;&lt;br&gt;- Discharge potential;&lt;br&gt;- Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and&lt;br&gt;- Documentation of participation in assessment.</td>
<td>F272</td>
<td><strong>Facility will, initially and periodically, conduct a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</strong>&lt;br&gt;<strong>MDS Coordinator/Designee reviewed MDS's for residents #39, #43 and #49 and corrections have been made to ensure accuracy. (8/22/12)</strong>&lt;br&gt;<strong>MDS Coordinator/Designee will initially review all Minimum Data Set (MDS) for accuracy.</strong>&lt;br&gt;**MDS Coordinator has been re-educated by DON regarding accurate assessment and required documentation. During the weekly care plan meeting, all MDS's due for submission, are now reviewed for accuracy before transmitting.</td>
<td>9/14/12</td>
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F 272 Continued From page 4

by:

Based on medical record review, observation and interview, it was determined the facility failed to ensure an accurate and comprehensive assessment was completed for 3 of 20 (Residents #39, 43 and 49) sampled residents of the 23 residents included in the stage 2 review.

The findings included:

1. Medical record review for Resident #39 documented the resident admitted 5/16/08 with diagnoses of Traumatic Subdural Hemorrhage, Multi Joint Contractures, Gastrostomy, Anemia, Craniotomy, Abnormal Posture, Incontinence, Persistent Vegetative State, Muscle Spasm, Hypertension and Spastic Paresis of upper and lower extremities. Review of the quarterly Minimum Data Set (MDS) dated 1/24/12 documented the resident as receiving range of motion (ROM) and having impairment on bilateral upper and lower extremities. The quarterly MDS's dated 4/24/12 and 7/24/12 documented the resident was not getting ROM and still having impairment on bilateral upper and lower extremities. The care plan dated 4/27/12 included the problem of multiple contractures and the intervention of "ROM with all ad[activity of daily living]."

Observations in Resident #39's room on 8/22/12 at 8:00 AM, revealed Resident #39 awake, lying in bed on her back, with the head of bed elevated. The TV was on in Resident #39's room. Resident #39 was nonverbal when spoken to, but did look at the surveyor. Resident #39 was noted to have spastic arms.

Continued From pg.4

5.) The MDS documentation will be reviewed by the nursing interdisciplinary team during weekly care plan meeting and any issues noted will be corrected at time of discover and reported to the QA/QI committee monthly until resolved.
Continued From page 5

During an interview at the nurse's station on 8/22/12 at 8:45 AM, Nurse #2 stated, "She [Resident #39] gets ROM with all ADL care, she is very spastic."

2. Medical record review for Resident #43 documented an admission to the facility on 12/13/09 with diagnoses of Alzheimers, Anemia, and Dysphagia. The quarterly MDS dated 3/5/12 documented the resident's vision as adequate. The 6 day MDS dated 8/21/12 and the 14 day MDS dated 8/28/12 documented the resident's vision as being impaired.

Observations in the lobby on 8/21/12 at 11:20 AM, revealed Resident #43 seated in a gerichair waiting for lunch. Resident #43 was awake but non-verbal and no eye contact made.

During an interview in the conference room on 8/2/12 at 4:00 PM, the MDS Coordinator was asked what caused the change in vision documentation on the MDS. The MDS Coordinator stated, "It is perception on my part, since March [2012] he has gotten worse, Alzheimer's is much worse, he no longer feeds himself, very little eye contact made, whether it is his Alzheimer's or actual vision I don't know."

3. Medical record review for Resident #49 documented an admission date of 12/9/11 with diagnoses of Diabetes Mellitus, Schizophrenia, Gout, Uncontrolled Hypertension, Hypothyroid, Coronary Artery Disease, Post Traumatic Stress Disorder, Left Eye Blind, Optic Nerve Injury and Bipolar. Review of the initial psychosocial assessment dated 11/12/11 documented, "...legally blind..." Review
**F 272**

Continued From page 6 of the care plan dated 12/19/11 documented, "...Resident has impaired vision..." with interventions to encourage resident to wear glasses, place resident in front near activities and keep room well lit and clutter free. Review of the MDS dated 3/12/12 documented, "...Vision... 0. Adequate..." Review of the MDS dated 8/11/12 documented, "...Vision... 1. Impaired..."

During an interview in the MDS office on 8/21/12 at 2:00 PM, the MDS Coordinator was asked why the difference in the vision assessment on the last two MDS. The MDS Coordinator stated, "...it was an inaccurate answer [on the 3/12/12 MDS]."

**F 279**

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 timelines to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

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

(H1) PROVIDER/SUPPLIER/CLINIC IDENTIFICATION NUMBER:
HILLVIEW COMMUNITY LIVING CENTER

445387

(H2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

08/22/2012

STREET ADDRESS, CITY, STATE, ZIP CODE
977 EVERGREEN STREET, PO BOX 766
DRESDEN, TN 38226

(H3) DATE SURVEY COMPLETED
08/22/2012

NAME OF PROVIDER OR SUPPLIER

(F4) ID PREFIX TAG

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

(F5) ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 279 Continued From page 7

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 develop a comprehensive plan of care for range of motion (ROM) or hospice care for 2 of 20 (Residents #47 and 60) sampled residents of the 23 residents included in the stage 2 review.
The findings included:
1. Review of the facility's care plan policy dated 6/1/00 documented "...1. An Interdisciplinary team... develops and maintains a comprehensive care plan for each resident..."
2. Medical record review for Resident #47 documented an admission date of 1/19/11 with diagnoses of Adult Physical Abuse, Alzheimer's Disease, Hypothyroidism, Mental Disorder, Migraine, Osteoporosis, Syncopeal Episides, Depressive Disorder, Back Contusion and Symbolic Dysfunction. Review of the annual Minimum Data Set (MDS) dated 1/27/12 revealed section G had no impairment of the upper and lower extremities documented. Review of the quarterly MDS dated 7/18/12 revealed section G had impairment on upper and lower extremities on one side. The comprehensive care plan dated 1/27/12 and updated on 7/19/12 does not address the impairment of upper and lower extremities on one side or ROM needs.
Observations on the east hall on 8/20/12 at 10:00 AM, revealed Resident #47 ambulating

Continued From pg.8

5.) Care Plans will be reviewed by the nursing interdisciplinary team during care plan meetings weekly and any issues discovered will be corrected and reported to the QA/QI committee monthly for follow-up until issues are resolved.
Continued from page 8

Observations in the dining room on 8/20/12 at 11:50 AM, revealed Resident #47 used both upper extremities during the lunch meal.

During an interview in the MDS Coordinator’s office on 8/22/12 at 8:30 AM, the MDS Coordinator was asked if ROM was addressed in the care plan. The MDS Coordinator stated, “...I know it's not...”

3. Medical record review for Resident #60 documented an admission date of 8/7/12 with diagnoses of Depressive Disorder, Edema, Anxiety, Chronic Kidney Disease Stage IV, Hypertension, Congestive Heart Failure and Atrial Fibrillation. Review of the admission orders dated 8/7/12 documented, “...Admit to... hospice - respite care...” Review of the admission MDS dated 8/11/12 documented the resident’s life expectancy is less than 6 months and receiving hospice care. Review of the care plan dated 8/11/12 documented, risk for decline in psychosocial well being related to disease progression and hospice care. There was no comprehensive plan of care developed for hospice care for Resident #60 to address the coordinated plan of care between the facility and hospice.

During an interview at the nurses’ station on 8/21/12 at 10:55 AM, Nurse #4 was asked how often hospice staff visited Resident #60. Nurse #4 stated, “...the hospice CNA [certified nursing assistant] comes out daily... the hospice LFN [licensed practical nurse] comes out about 3 times each week and the hospice RN [registered
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<th>COMPLETION DATE</th>
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| F 279        | Continued From page 9 nurse] comes out about 2 or 3 times each week...<br><br>During an interview in the MDS Coordinator's office on 8/21/12 at 11:15 AM, the MDS Coordinator was asked if the facility developed a comprehensive plan of care for hospice care for Resident #60. The MDS Coordinator stated, "...there is not a specific care plan for hospice..."<br><br>During an interview on the east hall on 8/22/12 at 8:54 AM, Nurse #4 was asked about the coordination of care between the facility staff and the Hospice staff. Nurse #4 stated, "...we're not sure when the hospice aides will be here... also true of the nurses [hospice nurses]... they don't come the same time every day..."<br><br>During an interview in the lobby on 8/22/12 at 9:20 AM, hospice CNA #1 was asked about the coordination of care between the facility staff and the hospice staff. Hospice CNA #1 stated, "...she [Resident #60] usually gets a shower in the morning... sometimes she gets a shower in the morning before I get here... sometimes I come in the afternoon..." Hospice CNA #1 was asked if the facility staff always know when the hospice staff will be in the facility to visit Resident #60. Hospice CNA #1 stated, "No."
| F 279        |                                                                                                      |              |                                                                                                       |                |
## F 279 Continued From page 10

In the facility to visit Resident #60, CNA #1 stated, "...there are times when we don't always know that [when hospice staff would arrive]..."

During an interview in the Director of Nursing's (DON) office on 8/22/12 at 9:15 AM, the DON was asked if the facility had a comprehensive plan of care for Resident #60 which addressed coordinated care between the facility and hospice. The DON stated, "No." The DON was asked how often the hospice staff visited Resident #60. The DON stated, "...the [hospice] nurse comes in 3 times a week... the [hospice] aide comes in 2 times a week..."

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

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

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

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<th>COMPLETION DATE</th>
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<td>F 279</td>
<td>1. Facility will ensure residents' care plans are updated for pain and falls.</td>
<td>9/14/12</td>
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<td></td>
<td>2. MDS Coordinator/Designee has updated resident #17's pain care plan. MDS Coordinator/Designee</td>
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<td></td>
<td>has implemented a care plan for the coordination of care between the facility and hospice for</td>
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<td>resident #60. (8/22/12)</td>
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<td>3. Director of Nursing/Designee has completed a Care plan audit to ensure resident care plans</td>
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<td>are accurate and up to date.</td>
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<td>4. Director of Nursing/Designee will in-service/educate the MDS Coordinator &amp; charge nurses</td>
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<td>regarding the development &amp; revision of care plans. 24 hour report, I&amp;A process, &amp; telephone</td>
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<td>orders, and weekly PAR meeting will be</td>
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This **REQUIREMENT** is not met as evidenced by:

- Based on policy review, medical record review and interview, it was determined the facility failed to ensure residents’ care plans were reviewed for pain medication or falls for 2 of 20 (Residents #17 and 23) sampled residents reviewed of the 23 residents included in the stage 2 review.

The findings included:

1. Review of the facility’s fall risk management policy documented, "...interventions will be implemented as needed to help manage the potential for falls and assist in minimizing the risk. Interventions will be re-evaluated for effectiveness during care planning and as needed... When using a fall risk assessment data tool, if the score is equal to or greater than the preset high risk score the resident is to be considered at risk for falls... The fall risk care plan is to be updated after each fall... Interventions - Using the completed risk assessment tool, evaluate which areas need to be addressed and what interventions need to be put in place..."

Review of the facility’s falls policy documented, 

"...if the score of the assessment is above 10, the resident will be considered at risk for falls and the falls potential should be addressed on the resident’s care plan and the CNAs [certified nursing assistant] Information Sheet. If the resident has fallen, the resident will be considered at risk, regardless of the score... If a fall occurs... Care plan needs to be updated with each fall..."
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<th>(X5) COMPLETION DATE</th>
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<td>F 280</td>
<td>Continued From page 12 Review of the facility's care plan policy documented, &quot;...Care plans are revised as changes in the resident's condition dictates...&quot; 2. Medical record review for Resident #17 documented an admission date of 1/21/05 with diagnoses of Chronic Airway Obstruction, Myalgia, History of Cerebrovascular Accident, Depressive Disorder, Esophageal Reflux, Hypertension, Hyperlipidemia, History of Rhabdomyolysis, Osteoarthritis, Low Estrogen Syndrome, Hypothyroidism, Hialtal Hernia, Osteoporosis, Cardiomyopathy, Hyperlipidemia, Dizziness and Insomnia. Review of a physician's order dated 8/15/12 documented, &quot;...HYDROCODONE: APAP 5-500 TABLET 1 PO [by mouth] BID [twice daily] - NO LATER THAN 4 PM FOR PAIN...&quot; Review of the care plan dated 12/8/11 and reviewed 8/6/12 documented, &quot;...Resident has complaints of pain but now only has tylenol and is relieved, tramadol was dcs [discontinued] and hydrocodone is dcd [discontinued]... relieve pain with use of tylenol...&quot; During an interview at the nurses' station on 8/21/12 at 2:15 PM, Nurse #1 was asked if Resident #17 received hydrocodone. Nurse #1 reviewed the care plan and stated, &quot;Looks like it [hydrocodone] should have been on here. It's still ordered BID. I don't have an answer for you as to why it's got the hydrocodone was dcd...&quot; 3. Medical record review for Resident #23 documented an admission date of 3/23/12 with a readmission date of 6/4/12 with diagnoses of Congestive Heart Failure, Hypertension, Chronic Kidney Disease, Diabetes Mellitus and Idiopathic Peripheral Neuropathy. Review of the fall risk</td>
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| evaluation dated 6/4/12 documented, documented a total score of 10 which represents a high risk for falls. Review of the fall risk evaluation dated 7/23/12 documented a score of 12 which represents a high risk. Review of a nurses' note dated 7/23/12 documented, "...resident fell & [and] hit her head. Has a knot above L [left] eye. [Symbol for no] c/o [complaints of] pain at this time... Resident encouraged to use call light in order to ask for assistance..." Review of the investigation summary dated 7/23/12 documented, "...Interventions in place at time of event... call light in place..." Review of the incident report dated 7/23/12 documented, "...Additional Comments and Measures Taken to Prevent Reoccurrence... The resident was encouraged to use the call light in order to ask for assistance..." Review of the care plan dated 4/4/12 documented, "...Risk for falls r/t weakness... Encourage to call for assistance pm [as needed]. Call light in reach... Answer calls for assistance promptly... staff to assist with transfers and adf's [activities for daily living]..." Review of the care plan updated on 7/23/12 documented, "...[Resident #23] fell & hit her head... Resident encouraged to use call light in order to ask for assistance..." During an interview in the hall outside the Physical Therapy department on 8/22/12 at 10:30 AM, Resident #23 was asked what instructions the staff gave her after she fell on 7/23/12 to prevent another fall. Resident #23 stated, "...they [staff] talked to me about using my call light..." Resident #23 was asked if she was instructed
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<td>F 280</td>
<td>Continued From page 14 about using the call light for assistance when she was admitted to the facility. Resident #23 stated, &quot;Yes.&quot; During an interview in the conference room on 8/22/12 at 10:48 AM, the Director of Nursing (DON) was asked what instructions are given to residents when they are first admitted. The DON stated, &quot;call light use in the bathroom and the bedroom.&quot; The DON was asked what intervention was put in place, to prevent another fall, for Resident #23 after her fall on 7/23/12. The DON stated, &quot;encourage to use call light for assistance.&quot; The DON was asked if this intervention was already in place. The DON stated, &quot;It was on the initial care plan dated 4/14/12.&quot;</td>
<td>F 280</td>
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<td>9/14/12</td>
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<td>F 309</td>
<td>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</td>
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<td>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.</td>
<td></td>
<td>1.) The facility will 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.</td>
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<td>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 a physician's order was followed and the dialysate used for peritoneal dialysis was documented for 1 of 23 (Resident #23) sampled residents of the 23 residents included in the stage 2 review.</td>
<td></td>
<td>2.) Medical Records Nurse/Designee completed a physician’s orders reviewed for resident #23. The current medication administration record (MAR) reflects the physician's orders. (8/23/12)</td>
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<td>3.) Medical Records Nurse/Designee completed a physician’s orders reviewed of the facility. (9/7/12)</td>
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<td>4.) Medical Records Nurse/Designee will review all incoming physician’s orders. Physician orders will be checked off the MAR and all</td>
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F 309 Continued From page 15

The findings included:

Review of the facility's "DIALYSIS: PERITONEAL DIALYSIS, GUIDELINES FOR CARE AND ASSESSMENT" policy documented, "...Treatment will be documented on a peritoneal dialysis flow sheet / MAR [medication administration record]... Follow instructions for peritoneal dialysis exchange as ordered by physician..."

Review of the facility's "POLICY AND PROCEDURE FOR CAPD [continuous ambulatory peritoneal dialysis]" policy documented, "...PERITONEAL DIALYSIS PARAMETERS... As noted in the dialysis manual fluid balance is an important part of peritoneal dialysis and can make a difference in the success of this intervention for compliance with CAPD... Should your blood pressure, weight, feeling tired or ill, swelling or edema or other signs of fluid imbalance occur, notify your dialysis nurse or physician to discuss if there is a need to change your dialysate concentration..."

Medical record review for Resident #23 documented an admission date of 3/23/12 with a readmission date of 6/4/12 with diagnoses of Congestive Heart Failure, Hypertension, Chronic Kidney Disease, Idiopathic Peripheral Neuropathy and Diabetes Mellitus. Review of a physician's order dated 7/12/12 documented, "...CCPD [continuous cycling peritoneal dialysis] 7X [times] WEEK TIDAL FILL VOLUME 2850 4 bags of 3000L [liter][3000 milliliter (ml)] or 3L each, use 4-2.5% [percent] dialysate bags nightly..."

Review of the care plan dated 4/4/12

Continued From pg. 15

discrepancies will be corrected and reported to the Director of Nursing. The findings will be brought to the QA/QI committee meeting monthly.

5.) Director of Nursing will review all of the findings of the Medical Records Nurse and in-service/reeducate nursing staff regarding the physician’s orders. Staff reeducation will be reported to the QA/QI committee monthly.
F 309 Continued From page 16 documented, "...End Stage Renal Disease: Dialysis Patient... Resident will have Peritoneal dialysis as ordered with undetected complications... Peritoneal dialysis as ordered... Notify MD [medical doctor] / RP [responsible party] for changes in condition..." Review of August 2012 "Peritoneal Dialysis Daily Record" revealed...# [number] Bags %... [was blank for August 1 through 21]..." Review of the August 2012 MAR had no documentation of the dialysate infused.

Observations in Resident #23's room on 8/20/12 at 1:30 PM, revealed Resident #23 lying in bed and a Liberty Cycler peritoneal dialysis system on the bedside dresser.

Observations and interview in room 3B on 8/21/12 at 4:45 PM, revealed several boxes of 3 liter-2.5% dialysate bags and 3 liter-1.5% dialysate bags stored on a cart. Nurse #6 confirmed these supplies were used for Resident #23.

During an interview at the nurses' station on 8/21/12 at 4:37 PM, Nurse #6 was asked about the procedure of peritoneal dialysis for Resident #23. Nurse #6 stated, "...we [facility nursing staff] put on 2-2.5 [2.5% dialysate] bags and 2-1.5 [1.5% dialysate] bags... if her [Resident #23] blood pressure is real low, we use all 1.5%... if her blood pressure is below 100 [systolic] or the bottom is below 50 [diastolic]..."

During an interview in conference room on 8/22/12 at 10:48 AM, the Director of Nursing (DON) was asked about the physician's order for peritoneal dialysis for Resident #23. The DON...
F 309
Continued From page 17
stated, "...it changes when she goes to the
dialysis clinic... they [dialysis clinic] told the
daughter [Resident #23’s daughter] about the
changes [change in dialysate order]..." The DON
was asked about the documentation of the
dialysate infused. The DON stated, "...it should be
on there [Peritoneal Dialysis Daily Record]... they
[facility nursing staff] did not document the
number of bags and percentages [of dialysate]."
The DON confirmed the current order for
dialysate was 4-2.5% dialysate bags nightly, but
the facility nurses were using 2-2.5% dialysate
bags and 2-1.5% dialysate bags nightly for
Resident #23.

During an interview in conference room on
8/22/12 at 12:05 PM, the DON was asked if the
facility’s nurses document any changes
concerning Resident #23’s peritoneal dialysis.
The DON stated, "...they [facility’s nursing staff]
should... in the nurses’ notes... or if there are
changes in orders, they should write a doctor’s
order..."
### F 332

Continued From page 18

Nurses administered medications with a medication error rate of less than five percent (%). There were 3 medication errors out of 53 opportunities for error, which resulted in a medication error rate of 5.6%.

The findings included:

1. Review of the "American Society of Consultant Pharmacists Geriatric Medication Handbook Tenth Edition" documented: "...NASAL MEDICATION ADMINISTRATION... 12. If possible, ask resident to gently blow their nose to remove excess mucus... 14. Resident should be sitting up, if possible. Instruct resident to hold head upright, slightly forward. 15. Gently press side of nostril that is not receiving medication using finger of other hand..."

Review of the facility's nasal inhaler, spray and pump administration policy documented, "To administer medications in a safe and accurate manner... B. Have resident blow his/her nose gently to clear the nostrils... Instruct resident keep head upright and slightly tilted forward... Spray firmly and quickly while the resident breathes in through their nose and out through their mouth..."

Medical record review for Resident #23 documented an admission date of 6/4/12 with diagnoses of Congestive Heart Failure, Esophageal Reflux Disease, Chronic Kidney Disease, Hypertension, Diabetes Mellitus and Peripheral Neuropathy. Review of a physician's order dated 7/12/12 documented, "...FLONASE 0.05% NASAL SPRAY 2 SPRAYS IN EACH NOSTRIL QD [daily]..."

### F 332

Continued From pg.18

signs/symptoms of adverse effects. No evidence of adverse effects. (9/7/12)

DON/Designee assessed resident #30 for signs/symptoms of adverse effects related to medication error. No evidence of adverse effects. (8/23/12) DON/Designee will audit resident charts with Metoclopramide for signs/symptoms of adverse effects. No evidence of adverse effects. (9/7/12) MD/RP notified of these med errors

Residents who receive medications have the potential to be affected by alleged deficient practice. MD/RP notified of these med errors.
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<th>F 332</th>
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<td>Observations in the therapy room on 8/21/12 at 8:32 AM, revealed Resident #23 lying on a therapy table in the therapy room. Nurse #4 handed a container of Flonase 0.05% nasal spray to Resident #23. Resident #23 administered 2 sprays of the Flonase into each nostril while lying on the therapy table. Failure to instruct the resident to blow her nose and to sit upright and tilt the head forward resulted in medication error #1.</td>
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2. Medical record review for Resident #60 documented an admission date of 8/7/12 with diagnoses of Diabetes Mellitus, Anemia, Anxiety, Hypertension, Atrial Fibrillation, Congestive Heart Failure, and Edema. Review of a physician's order dated 8/7/12 documented, "...Digoxin 0.125mg [milligrams] PO [by mouth] daily... Losartan 50mg PO BID [twice daily]... Ranitidine 150mg PO daily... Perhexiline 20mg PO daily... Torsemide 20mg PO BID... Lorazepam 0.5mg q [every] 8 hr pm [as needed]... Tramadol 50mg po TID (three times daily)... Atarax 25mg PO TID pm..." Review of a physician's order dated 8/17/12 documented, "...Isosorbide Mononitrate 30mg ER [extended release] po q..." |

Observations in room 3 on 9/22/12 at 7:29 AM, Nurse #4 administered Losartan 50mg, Torsemide 20mg, Digoxin 0.125mg, Perhexiline 20mg, Ranitidine 150mg, Hydroxyzine HCL 25mg, Tramadol HCL 50mg and Lorazepam 0.5mg by mouth to Resident #60. Failure to administer Isosorbide Mononitrate 30mg ER resulted in medication error #2. |

During an interview in the east hall on 8/22/12 at 8:40 AM, Nurse #4 was asked if Resident #60 was given the Isosorbide Mononitrate 30mg.
F 332

Continued From page 20

Nurse #4 reviewed the medication administration record and stated, "I thought I did. It's not signed off though. I guess I missed it."


Observations in room 18 on 8/20/12 at 4:15 PM, Nurse #5 administered 15mg [15mg] of Metoclopramide 5mg5ml to Resident #30. Failure to administer 10mg of the medication as ordered resulted in medication error #3.

F 425

1.) The facility will provide routine and emergency drugs and biologicals to meet its resident's needs.

2.) DON/Designee assessed resident #8 for signs/symptoms of adverse effects related to medication error. No evidence of adverse effects. DON/Designee will review resident #8 Physician orders and ensure the facility is providing all needed medications. (8/23/12).

3.) DON/Designee will complete a "match back" of each med cart (verifying medications ordered on MAR are available in the med cart).

4.) Licensed nurses will be re-educated regarding procedure for ordering/obtaining newly ordered medications from pharmacy (to include back up
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**F 425 Continued From page 21**

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 provide medications in a timely manner for 1 of 10 (Resident #8) sampled residents reviewed during the medication administration pass.

The findings included:

Review of the facility's "ORDERING AND RECEIVING MEDICATIONS FROM THE DISPENSING PHARMACY" policy documented, "...Medications and related products are received from the dispensing pharmacy on a timely basis..."

Medical record review for Resident #8 documented an admission date of 5/11/01 with diagnoses of Osteoarthritis, Convulsions, Anemia, Hyperlipidemia, Joint Pain and Muscle Weakness. Review of a physician's order dated 8/18/12 documented, "...AMITIZA 24 MG [micrograms] CAPSULE 1 PO [by mouth] BID [twice daily]..." [symbol for change] to 8 mg 1 po BID 8/18/12..." Review of the August 2012 Medication Administration Record (MAR) documented, "...Amitiza 8 mg 1 po Bid

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**PROVIDERS PLAN OF CORRECTION**

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<th>COMPLETION DATE</th>
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<tr>
<td>F 425</td>
<td>Continued From pg.21 pharmacy. Licensed nursing will also be re-educated regarding notifying physician when medication is not available to obtain a new order. Medical Records will verify each newly ordered med is available on medication cart. 5.) DON / designee will complete a monthly match back of both med carts to ensure medications ordered on the MAR are available in the medication cart. DON/Designee will audit medication carts monthly via the &quot;match back&quot; process. Any issues noted will be addressed and reported to QA/QI monthly until the alleged deficient practice is resolved.</td>
<td>08/22/2012</td>
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<tr>
<td>ID</td>
<td>PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
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<td>F 425</td>
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<td>Continued From page 22 8/16/12... From 8/17/12 through 8/21/12 there was no documentation that Amitiza 8 mg had been administered to Resident #8. During an interview in the west hall on 8/22/12 at 8:05 AM, Nurse #2 stated, &quot;...He [Resident #8] Amitiza was lowered on 8/16/12 but the pharmacy has never sent it. The order has been faxed into them, but it's still not here. We have this problem all the time with this pharmacy. I will contact them again today.&quot;</td>
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<td>F 431</td>
<td>SS-D</td>
<td>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</td>
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Form: OMB No. 0938-0391
Event ID: TWIN11
Facility ID: TWIN202
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<table>
<thead>
<tr>
<th>ID TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
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<td>F 431</td>
<td>Continued From pg.23</td>
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<td>storage/labeling. DON/Designee will make mediation pass and observations of medication carts to ensure cards are locked at all times. Findings will be reported to the OA/QI committee monthly.</td>
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**Continued From page 23**

Controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 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, review of the med-pass medications with shortened expiration dates provided by the American society of consultant pharmacists, observation and interview, it was determined the facility failed to ensure medications were not stored past their open / expiration date; dated when opened and that medications were stored in locked compartments in 2 of 4 (Medication room and West hall medication cart) medication storage areas.

The findings included:

1. Review of the med-pass medications with shortened expiration dates provided by the American society of consultant pharmacists documented, "...Insulin: Humulin, Humalog, Novolog, Lantus, Apidra... NOTES: Vial expire 28 days after opening / puncturing or after removing from refrigerator, whichever comes first..."

   Review of the facility's vials and ampules of injectable medications policy documented, "...The date opened and the initials of the first person to use the vial are recorded on multidose vials on the vial label or an accessory label affixed for that purpose."
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<td>F 431</td>
<td>Continued From page 24 purpose... “Observations in the medication room on 8/21/12 at 8:38 AM, revealed a vial of Lantus insulin not dated when opened. During an interview in the medication room on 8/21/12 at 8:50 AM, Nurse #4 was asked when was the vial of Lantus insulin to be discarded. Nurse #4 looked at the vial of insulin and stated, &quot;It must have been opened about 4 days ago. The date is not on here. It should be discarded after 28 days, but you don't know when that is for this vial.&quot; 2. Review of the facility's &quot;Storage of Drugs and Biologicals&quot; policy documented, &quot;...All drugs and biologicals are stored in locked compartments...&quot; Observations in the west hall on 8/20/12 at 4:15 PM, revealed the west hall medication cart was unlocked, unattended and out of the nurse's view. During an interview in the west hall on 8/20/12 at 4:26 PM, Nurse #5 was asked if the medication cart was locked. Nurse #5 stated, &quot;No. I'm supposed to lock it each time I leave and go in a room.&quot;</td>
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