**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<tr>
<th>ID</th>
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<tr>
<td>F000</td>
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<td>449439</td>
<td>INITIAL COMMENTS</td>
<td>F241 P241 483.15(a) Dignity and Respect of Individuality</td>
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### INITIAL COMMENTS

An annual recertification survey and complaint investigation #s 24583, 24768, 25685, were completed on August 24-26, 2010 at Mt. Juliet Health Care Center. No deficiencies were cited in relation to the complaint investigation #s 24583, 24768, and 25685, under 42 CFR Part 483.15, Requirements for Long Term Care Facilities.

#### F 241 DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

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

- Based on observation and interview the facility failed to promote care in a manner that maintained or enhanced each resident's dignity for four residents (#14, #16, #17, #21) of twenty-three residents reviewed.

The findings included:

- Observation on August 25, 2010, at 8:15 a.m. through 8:30 a.m., revealed Certified Nurse Assistant (CNA) #2 standing while feeding residents #14, #16, #17, and #21 in the dining room.

- Interview with the Director of Nursing (DON) in the dining room during the observation on August 25, 2010, at 8:30 a.m., confirmed CNA #2 standing and feeding the residents was not a manner and an environment that enhanced dignity for residents while eating.

### Corrective Action:

1. The Certified Nursing Assistant was instructed immediately by DON at time of observation on proper feeding position to promote dignity.
2. All residents that required total assistance with meals will be assisted with CNA/staff maintaining correct positioning at eye level to promote dignity and respect.
3. Educate all nursing staff regarding proper feeding for total assist residents.
4. Dining room practices will be monitored weekly by DON/ADON or designee. Review of mealtime will be discussed with QA Committee.

**LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

[Signature]

**DATE**

9/8/10
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<tr>
<th>F-281</th>
<th>453.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</th>
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<tr>
<td>SS-15</td>
<td>F 281 483.20 (k)(3)(i) SS-15</td>
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<tr>
<td></td>
<td><strong>Requirement:</strong> The service provided or arranged by the facility must meet professional standards of quality.</td>
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<td><strong>Corrective Action:</strong></td>
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<tr>
<td></td>
<td>1. Resident #15's MD was notified on 8/25/10 of medication transcription and omission error. New order received to change Ranitidine 150 mg from BID to QD. Resident #20 discharged from facility on 1/30/09.</td>
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<td>2. All resident's MARS will be reconciled with current MD orders to ensure proper administration practices by DON/ADON or designee.</td>
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<td>3. Two Nurses are to sign monthly orders to ensure accuracy and completion with reconciliation. Staff education on correct procedure on end of month reconciliation with past orders, MAR, and new month MD orders.</td>
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<td>4. Weekly audit (25% sample) will be conducted by Risk Management Nurse or designee for safe administration practices to ensure MD orders and MARS are correctly reconciled. Audits will be reviewed in monthly pharmacy meeting and areas of non-compliance will be corrected per facility protocol and reviewed in quarterly QA.</td>
</tr>
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The findings included:

- Resident #15 was admitted to the facility on July 21, 2010, with diagnoses including Gastroesophageal Reflux Disease, Cardiopulmonary Accident, Peripheral Vascular Disease, and Hyperlipidemia.

- Medical record review of the August 2010, physician's recertification orders revealed the resident was to receive Ranitidine (anti-ulcer medication) 150 mg (milligrams) twice a day.

- Medical record review of the August 2010, Routine Medications record revealed the Ranitidine 150 mg was administered once daily August 1-24, 2010.

- Interview on August 25, 2010, at 8:10 a.m., with the Director of Nursing, at the nursing station, confirmed the Ranitidine 150 mg was not administered twice a day from August 1-24, 2010, and confirmed the physician's orders were not followed.

- Resident #20 was admitted to the facility on
STATEMENT OF DEFICIENCY AND PLAN OF CORRECTION

MT JULIET HEALTH CARE CENTER

- SUMMARY STATEMENT OF DEFICIENCIES - EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LCD IDENTIFYING INFORMATION

F 281
Continued From page 2. November 25, 2009 with diagnoses including Congestive Heart Failure, Atrial Fibrillation, and Senile Dementia. Medical record review revealed the resident was discharged home on November 30, 2009.

Medical record review of the physician's orders dated November 25, 2009, revealed the resident was to receive Lasix (diuretic) 10 mg every other day.

Medical record review of the November 25-30, 2009, Medication Record revealed the resident received the Lasix 10 mg on November 27-30, 2009, (daily for four days).

Interview on August 28, 2010, at 1:00 p.m., with the Director of Nursing, in the conference room, confirmed the Lasix 10 mg was administered daily from November 27-30, 2009, and confirmed the physician's orders were not followed.

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.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to implement the care plan for two residents (#6, #9) of twenty-three residents reviewed.

The findings included:

F 282 483.20 (K)(3)(ii) Services by qualified persons / per care plan SS-D

Requirement:
The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care.

Corrective Action:
1. Resident #6 is receiving sandwich with lunch and dinner tray daily, Resident #9's TED hose d/c due to non-compliance. Geriatric ADS to bilateral lower extremities and bilateral lower extremities in place per plan of care. Non-skid socks in place.

9/8/10
Resident #6 was admitted to the facility on March 12, 2005, with diagnoses including End Stage Renal Disease, Chronic Obstructive Pulmonary Disease, Anxiety, and Hypertension. Medical record review revealed the resident began receiving hospice services on February 12, 2010.

Medical record review of the Plan of Care dated June 18, 2010, revealed "lack of feeding ... risk for weight loss...mech (mechanical) soft diet add sandwich to meals & other finger foods." 

Observation on August 24, 2010, from 12:22 p.m. until 12:40 p.m., revealed the resident seated in a wheelchair, at a table in the small dining room. Continued observation revealed there was no sandwich on the resident's tray and the resident was feeding self sweet potatoes and chopped ham with the fingers.

Observation on August 25, 2010, at 12:35 p.m., revealed the resident seated in a wheelchair, at a table in the small dining room. Continued observation revealed there was no sandwich on the resident's tray, and the resident was feeding self spinach with cheese, chopped beef, fried potatoes, and chocolate pie with the fingers.

Observation and interview on August 25, 2010, at 12:40 p.m., with the Assistant Director of Nursing, revealed the resident feeding self pie with the fingers, and confirmed there was no sandwich or other finger foods provided with the lunch meal and the Plan of Care was not followed.

Resident #9 was admitted to the facility on October 27, 2008, with diagnoses including Dementia, Neurotic Disorder, Anxiety, and History of Fractured Femur (long bone in leg).
Medical record review of the Minimum Data Set dated July 2, 2010, revealed the resident had impaired short and long term memory and required assistance with all activities of daily living.

Medical record review of the nurse’s notes dated May 1, 2010, to August 28, 2010, revealed the resident had frequent skin tears to the arms and legs, including a skin tear on the right leg that required stitches on May 18, 2010.

Medical record review of the resident’s current care plan, revised on July 7, 2010, revealed “...TED hose (without stockings) when up in wc (wheel chair) with gripper socks as tolerated...geri sleeves (cotton sleeves) to decrease skin tears...BLE (both lower extremities) BLE (both lower extremities) as tolerated. Encourage (resident) to wear geri sleeves. Encourage protective sleeves to upper and lower extremities at all times as (resident) tolerates while in and out of bed...apply non-skid socks when shoes are removed.”

Observation with Licensed Practical Nurse (LPN) #1 on August 26, 2010, at 8:48 a.m., in the resident’s room revealed the resident sitting in the wheelchair with regular socks (not non-skid), no geri sleeves on the arms or legs, and no TED hose applied: Interview with LPN #1 confirmed the resident’s care plan was not implemented.

Observation and interview on August 26, 2010, at 9:55 a.m., with Certified Nurse Assistant (CNA) #1 in the resident's room revealed no geri sleeves or non-skid socks in the resident's room, and the TED hose were in a drawer. Interview with CNA #2 confirmed the resident’s care plan was not
F 262 Continued From page 5
Implimented.

F 322 483.25(g)(2) No Treatment/Services - Restore Eating Skills

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a nasogastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, facility policy review, and interview, the facility failed to label and date a tube feeding formula for one resident (#4) of twenty-three residents reviewed.

The findings included:
Resident #4 was admitted to the facility on July 15, 2010, with diagnoses including Cardiovascular Accident (Stroke), Dysphagia, and Perforated Gastrostomy Tube (PEG Tube - a tube placed in the stomach as a means of feeding when unable to eat).

Medical record review of the August 2010, Physician's Recertification Orders revealed, "Jevity 1.2 Cal at 60 ml (milliliters) per hour..."

Observation on August 26, 2010, at 7:35 a.m., revealed a 1000 ml bottle of Jevity 1.2 Cal hanging and infusing via pump. Continued observation revealed the label on the bottle of the
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MT JULIET HEALTH CARE CENTER

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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Jevity 1.2 Cal was blank and did not include the rate per hour, date, resident's name and the initials of the nurse.

Review of the facility's Enteral Tube Management/Medication Administration guidelines dated January 2005 revealed: "...The tube feeding...will be properly labeled with type of formula, rate per hour, date, patient's name and the initials of the nurse...This applies to any tube feeding whether by NG tube, percutaneous gastrostomy tube..."

Interview with Licensed Practical Nurse (LPN) #3 on August 25, 2010, at 7:45 a.m., in the resident's room, confirmed the facility failed to label the bottle of Jevity 1.2 Cal according to facility policy and procedure.

F 323
483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents:

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to ensure a safety device was in place or functional for two residents (#14, #12) of twenty-three residents reviewed.

The findings included:

F 323
F323 483.25 (h) Free of accident hazards / supervision / devices SS-D

Requirement:
The facility will ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

Corrective Action:
1. Resident #14's personal alarm was discontinued on 8-9-10. 8-9-10
   Wheelchair sensor pad was placed on 8-9-10. Resident #12's wheelchair alarming device has been discontinued per MD order.
2. Residents in the facility have been re-assessed by the licensed nurses for high risk of falls. If identified

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Resident #14 was admitted to the facility on June 7, 2010, with diagnoses including Alzheimer’s Disease, Osteoporosis, and Hypertension.

Medical record review of the Minimum Data Set (MDS) dated June 12, 2010, revealed the resident had severely impaired cognitive skills and required extensive assistance with transfers.

Medical record review of the Fall Risk Assessment dated July 6, 2010, revealed the resident was at high risk for falls.

Medical record review of the Plan of Care dated June 22, 2010, revealed the resident was at risk for falls and a personal body alarm was to be used.

Medical record review of a nursing note dated August 9, 2010, at 11:00 a.m., revealed the resident was found lying in front of the wheelchair and the personal body alarm was not in place. Continued review of the nursing note revealed the resident did not experience any injury related to the fall.

Observation on August 25, 2010, at 3:15 p.m., revealed the resident lying on a low bed, with a fall mat and a pressure sensitive alarm in place.

Interview on August 25, 2010, at 8:00 a.m., with the Director of Nursing (DON) in the conference room, revealed the DON had investigated the resident’s fall on August 25, 2010, and confirmed the personal body alarm was not in place at the time of the fall on August 25, 2010.

Resident #12 was admitted to the facility on December 12, 2007, with diagnoses including...
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

#### (X) PROVIDER/ SUPPLIER IDENTIFICATION NUMBER:

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<td>483.75(4) RES RECORDS COMPLETE/ACCURATE/ACCESSIBLE</td>
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<tr>
<td>F 514</td>
<td>3</td>
<td>483.75(4) Resident records are complete/accurate/accessible SS=D</td>
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#### SUMMARY STATEMENT OF DEFICIENCIES

**F 328**
Continued From page 8.
Senile Dementia With Delusional Features, History of Stroke, and Macular Degeneration (affects the eyesight).

Medical record review of the Minimum Data Set dated July 1, 2010, revealed the resident had impaired short term memory; impaired decision making skills, required assistance with all activities of daily living including transfers, and the resident had fallen in the past 31-180 days.

Medical record review of the August 2010, physician's recaptations orders revealed "... chief and with sensor alarm...".

Observation on August 24, 2010, at 3:00 p.m., in the hallway just outside of the dining room, revealed the resident stood from the wheel chair and no alarm sounded.

Observation and interview on August 25, 2010, at 12:35 p.m., with Licensed Practical Nurse (LPN) #2 and Housekeeper (HSK) #2 in the resident's room, near the hallway door revealed the resident standing behind the wheel chair, with no alarm sounding. Interview with LPN #2 and HSK #2 revealed the resident "...turns the alarm off all the time...", Continued interview confirmed the resident's alarm was not sounding to alert staff of an unsafe transfer.

#### (O) MULTIPLE CONSTRUCTION

**F 514**

#### PROVIDER'S PLAN OF CORRECTION

Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency

**SS=D**

The facility must maintain clinical records on each resident in accordance with acceptable professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.
F 514 Continued From page 9

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 and interview, the facility failed to maintain a complete medical record for one resident (#19) of twenty-three residents reviewed.

The findings included:

Resident #19 was admitted to the facility on August 17, 2009, with diagnoses including Failure to Thrive, Organ's Brain Syndrome (dementia), and Delirium.

Medical record review of a physician's order dated February 23, 2010, revealed the resident was sent to the emergency room.

Medical record review of the nurse's notes dated February 23, 2010, (no further notes after that time/date) revealed the resident was sent to the emergency room but did not indicate if the resident would return to the facility or had been discharged from the facility.

Medical record review of the social service notes revealed the last note was dated February 6, 2010. Continued review revealed no notation the resident was sent to the emergency room on February 23, 2010, and if the resident would
Return to the facility or if the resident was discharged from the facility.

Interview on August 26, 2010, at 11:00 a.m., in the conference room with the social services director confirmed the resident did not return to the facility when discharged from the hospital, was discharged from the facility on February 23, 2010, and the resident's medical record was not complete.